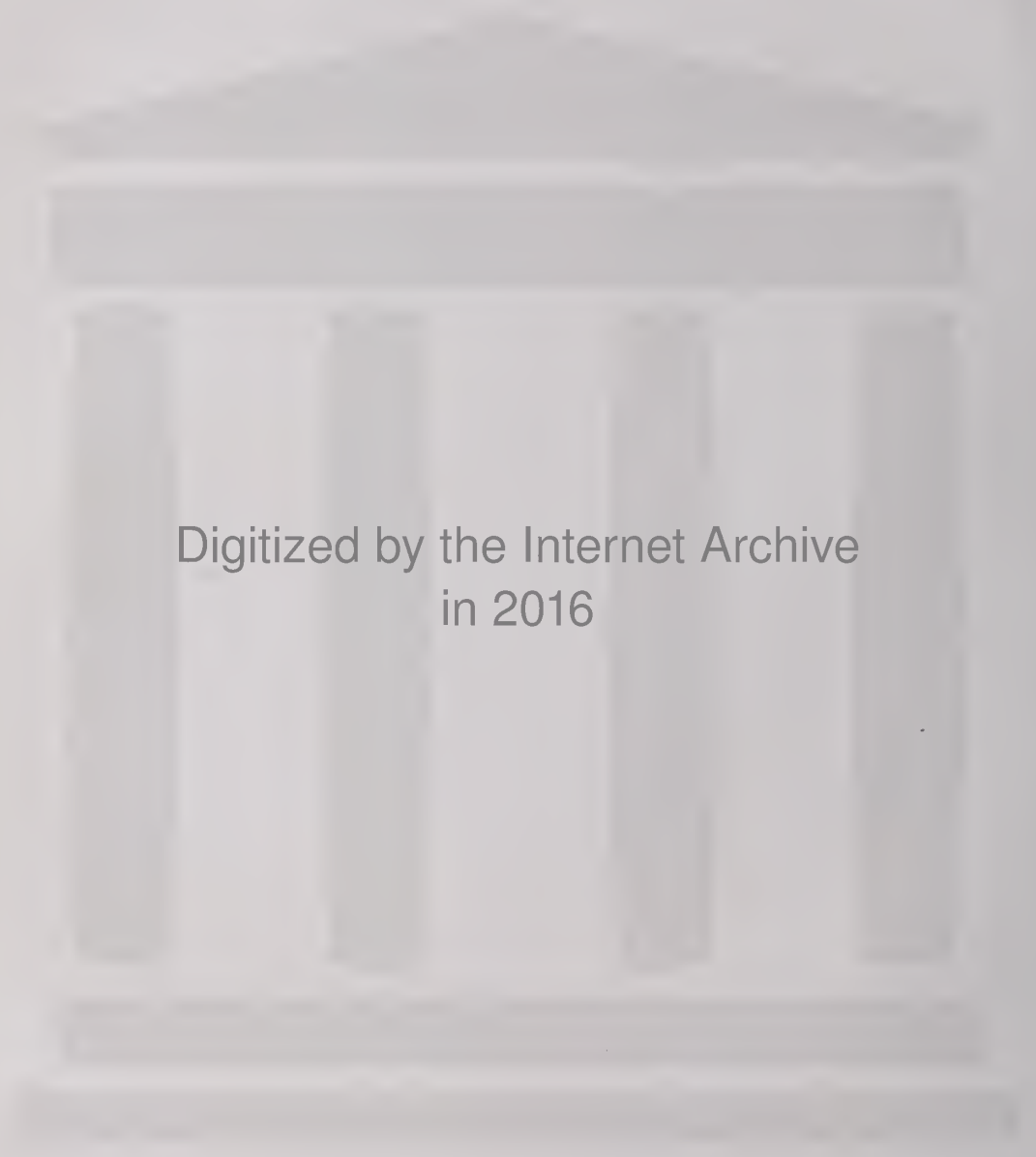
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THE FLORIDA MEDICAL ASSOCIATION, INC.

JANUARY 1978 • VOL 65 • NO 1

New FMA Headquarters in Jacksonville

104th Annual Meeting Scientific Program, See Page 49



Anxiety... Often a significant feature of irritable bowel syndrome*

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Please see brief summary of prescribing information on following page.

ROCHE

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Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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□ 21 and 28 day

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a step in the right direction

See the complete prescribing information for this product, a summary of which is on the next page.

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Ortho-Novum 1/50

TRADEMARK

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IMPORTANT NOTE—This information is a BRIEF SUMMARY of the complete prescribing information provided with the product and therefore should not be used as the sole basis for prescribing the product. This summary was prepared by deleting from the complete prescribing information certain text, tables, and references where indicated by the symbol [ ]. The physician should be thoroughly familiar with the complete prescribing information and patient information before prescribing the product. [ ].

INDICATION: Contraception [ ]

CONTRAINDICATIONS: Oral contraceptives (OC's) should not be used in women with any of the following conditions:

1. Thrombophlebitis, thromboembolic disorders or conditions which predispose to these disorders. 2. A past history of deep vein thrombophlebitis or thromboembolic disorders. 3. Cerebral vascular or coronary artery disease. 4. Known or suspected carcinoma of the breast. 5. Known or suspected estrogen-dependent neoplasia. 6. Undiagnosed, abnormal genital bleeding. 7. Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS:

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic. These studies estimate that users of oral contraceptives are 4 to 11 times more likely to develop these diseases without evident cause than are nonusers. Overall excess mortality due to pulmonary embolism or stroke is on the order of 1 0 to 3 5 deaths annually per 100,000 users and increases with age. In a collaborative American study of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2 0 times greater in users than in nonusers and the risk of thrombotic stroke was 4 to 9 5 times greater in users than in nonusers [ ] An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported, confirming a previously suspected association. These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor. The annual excess case rate (increased risk) of myocardial infarction (fatal and nonfatal) in oral contraceptive users was estimated to be approximately 7 cases per 100,000 women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group. [ ] In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives. Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 50-80 mcg of estrogen. Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved. This finding has been confirmed in the United States. Cases of thromboembolic disease have been reported in women using progestin-only oral contraceptives, and they should not be presumed to be free of excess risk.

The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age. Oral contraceptives are, however, an independent risk factor for these events. [ ]

The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception. The estimates of risk of death for each method include the combined risk of the contraceptive method (e g , thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure. This latter risk varies with the effectiveness of the contraceptive method. [ ] The study concluded that the mortality associated with all methods of birth control is low compared to the risk of childbirth, with the exception of oral contraceptives in women over 40, and that the lowest mortality is associated with the condom or diaphragm backed up by early abortion.

The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia. The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors. The use of oral contraceptives in women in this age group is not recommended.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e g., thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately.

A four- to six-fold increased risk of post-surgery thromboembolic complications has been reported in oral contraceptive users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery. [ ]

2. OCULAR LESIONS. There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives. Discontinue oral contraceptive medication if there is unexplained, sudden or gradual, partial or complete loss of vision; sudden onset of proptosis or diplopia, papilledema, or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures.

3. CARCINOMA. Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver. [ ]

In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives. [ ] One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in subgroups of oral contraceptive users with documented benign breast disease. A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented.

In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of all women taking oral contraceptives is, nevertheless, essential. In all cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception.

4. HEPATIC ADENOMA. Benign hepatic adenomas appear to be associated with the use of oral contraceptives. Although benign, and rare, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage. This has been reported in short-term as well as long-term users of oral contraceptives, although one study relates risk with duration of use of the contraceptive. While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock.

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. [ ]

5. USE IN PREGNANCY, BIRTH DEFECTS IN OFFSPRING, AND MALIGNANCY IN FEMALE OFFSPRING. The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception. Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes.

Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case control study has estimated a 4 7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal withdrawal tests for pregnancy or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 live births.

In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestins are effective for these uses.

There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives. Embryos with these anomalies are virtually always aborted spontaneously. Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown.

Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks. It is also recommended that women who discontinue oral contraceptives with the intent of becoming pregnant use an alternate form of contraception for a period of time before attempting to conceive. Many clinicians recommend 3 months.

The administration of progestin-only or progestin-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6. GALLBLADDER DISEASE. Studies report a doubling of the risk of surgically confirmed gallbladder disease in users of oral contraceptives or estrogen for 2 or more years.

7. CARBOHYDRATE AND LIPID METABOLIC EFFECTS. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives.

An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives.

8. ELEVATED BLOOD PRESSURE. An increase in blood pressure has been reported in patients receiving oral contraceptives. In some women hypertension may occur within a few months of beginning oral contraceptive use. In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers. The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year. Age is also strongly correlated with the development of hypertension in oral contraceptive users. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives.

9. HEADACHE. The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause.

10. BLEEDING IRREGULARITIES. Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind. In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy. [ ] Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since this may increase the risk of thromboembolic disease.

Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives. Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods.

11. ECTOPIC PREGNANCY. Ectopic as well as intrauterine pregnancy may occur in contraceptive failures. However, in oral contraceptive failures, the ratio of ectopic to intrauterine pregnancies is higher than in women who are not receiving oral contraceptives, since the drugs are more effective in preventing intrauterine than ectopic pregnancies. [ ]

12. BREAST FEEDING. Oral contraceptives given in the postpartum period interfere with lactation. There may be a decrease in the quantity and quality of the breast milk. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. [ ] If feasible, the use of oral contraceptives should be deferred until the infant has been weaned.

PRECAUTIONS: General 1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than 1 year without another physical examination being performed. 2. Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size. 3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree. Patients becoming significantly depressed while taking oral contraceptives should stop the medication. 4. Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, or cardiac or renal insufficiency. 5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy. If jaundice develops in any patient receiving such drugs, the medication should be discontinued. 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients. 7. Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency. 8. Serum folate levels may be depressed by oral contraceptive therapy. Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency. 9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted. 10. Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3, increased norepinephrine-induced platelet aggregability

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG, free T4 concentration is unaltered.

d. Decreased pregnanediol excretion.

e. Reduced response to metyrapone test.

INFORMATION FOR THE PATIENT (See Patient Package Insert)

DRUG INTERACTIONS: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin. [ ]

ADVERSE REACTIONS: An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see WARNINGS):

Thrombophlebitis, pulmonary embolism, coronary thrombosis, cerebral thrombosis, cerebral hemorrhage; hypertension, gallbladder disease, congenital anomalies.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed:

Mesenteric thrombosis; benign hepatomas, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related:

Nausea, usually the most common adverse experience; vomiting reaction, occurring in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally: gastrointestinal symptoms (such as abdominal cramps and bloating); breakthrough bleeding, spotting; change in menstrual flow, dysmenorrhea, amenorrhea during and after treatment, temporary infertility after discontinuance of treatment, edema, chloasma or melasma which may persist, breast changes: tenderness, enlargement and secretion, change in weight (increase or decrease); change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum; cholestatic jaundice, migraine, increase in size of uterine leiomyomata, rash (allergic); mental depression; reduced tolerance to carbohydrates; vaginal candidiasis.

The following adverse reactions have been reported in users of oral contraceptives, and the association has been neither confirmed nor refuted:

Premenstrual-like syndrome; intolerance to contact lenses, change in corneal curvature (steepening), cataracts; changes in libido, chorea, changes in appetite; cystitis-like syndrome, headache, nervousness, dizziness, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption; vaginitis, porphyria, impaired renal function.

ACUTE OVERDOSE: Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females. [ ]

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JANUARY COVER—Cover photograph of FMA's spacious new headquarters building in Jacksonville by Will Parham, son of FMA Executive Vice President W. Harold Parham, D.H.A. (See story on page 42).

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OCT 25 1979



Dean's Page

Chipping Away

Hollis G. Boren, M.D.

As the applicant to medical school answers the question of financing his or her medical education with phrases like "personal savings," "spouse's earnings," "help from parents," and "student loans," the applicant all too often fails to realize the role that the Federal Government is playing in his or her future as a physician. Certainly it is incumbent upon us as members of the Florida Medical Association to be knowledgeable about the problem of financial aid for medical students and to fully recognize how the shift of Federal philosophy and funding of health professions is chipping away at the incentives of prerogatives of our future practicing partners.

The magnitude of the problem may be indicated by the activation of the first Task Force on Student Financing of the Association of American Medical Colleges this year. A problem too grave for an individual problem solver or an ad hoc committee almost invariably requires a task force. The collective wisdom of a task force is assumed to provide an indepth analysis of the problem, the production of effective recommendations, and the political expertise to secure implementation of their recommendations. One can only lament that such is not the usual track record of task forces in general.

What's the story of the Task Force on Student Financing? A solid data base was established upon which realistic short term and long term recommendations were constructed. Then these recommendations ran into the dual obstacles of a thing called the Health Professions Educational Assistance Act of 1976 (PL 94-484) and the reluctance of the banking community to accept guaranteed student loans.

Where does this leave medical students? This year 16,000 new medical students will join 42,000 students already enrolled in United States medical schools. From 50 to 70 percent of these students will require financial aid from sources other than their savings, the earnings of their spouses, and help from their parents. They face an "aid gap" which amounts to a sum of $21 million nationally.

When the recommendations of the Task Force which centered on realistic mechanisms for securing student loans were proposed at the national level, they were not well received. They apparently were perceived as a threat to the National Health Service Corps Scholarship Program. The heart of this program is that participants agree to a commitment of one year of obligated public service in a federally-designated health manpower shortage area for each year of scholarship support. A minimum of two years of such service in full-time clinical practice is required. The lure to accept such an assignment must obviously be great. Living expenses of at least $400 per month in addition to educational expenses are provided. On the tail end a grant of $25,000 for two years to voluntarily practice in a designated shortage area is promised. Such monies must be attractive to our students who enter medical school with an average undergradaute debt of $3,400 and face annual costs of $5,640 if living with parents, $6,940 when living away from parents and $10,000 when married. I view with alarm the statistic that 36 percent of our students at the University of South Florida College of Medicine who are receiving loans have already incurred service obligations and its inevitable destructive impact upon the quality of medical practice.

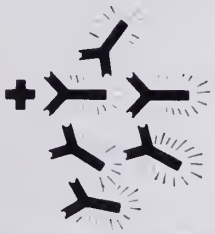
What can we do besides counsel students, seek help from the banking community, and work closer with the American Medical Association's Educational Research Fund loan program? I would submit that one course of action is for our county medical societies and the Florida Medical Association to consider establishing or expanding financial aid programs to medical students. Perhaps we can thereby diminish the process of chipping away the initiatives of future physicians and thereby at the quality of health care.

Dr. Boren is Director of the University of South Florida Medical Center and Dean of the College of Medicine, Tampa.

▶ Dr. Boren, University of South Florida, Tampa 33612.

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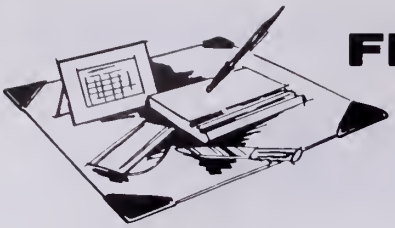
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FROM THE EDITOR'S DESK

FRAUD PENALTIES

President Carter has signed into law legislation increasing the penalties for fraud under the Medicare and Medicaid programs. Criminal fraud under both programs will be classified as a felony rather than a misdemeanor, with penalties including jail sentences up to five years and fines up to $25,000. The legislation prohibits "kickbacks" by providers and requires institutions to disclose financial and ownership information to the government. States may supercede PSRO functions if they can prove to the government that the PSRO decisions are having a detrimental impact on state Medicaid spending.

* * * *

FBI INVESTIGATION

The Justice Department is pitching in to help in health care investigations. According to Rep. Paul Rogers of Florida, 350 FBI agents have received training in auditing Medicare and Medicaid records. Another 1,100 G-men have had special auditing training that is applicable to health investigations in general.

* * * *

CHILD HEALTH

AMA has supported in principle the goals of the Child Health Assessment Act (HR 6796). But the AMA fears that the legislation as it now exists would detract from assuring full access to quality care. The bill would modify the current Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) to extend Medicaid EPSDT eligibility to children of low income families who do not qualify for Medicaid because of family structure. AMA told Rep. Paul Rogers of Florida, Chairman of a House health subcommittee, that any re-evaluation and revision in the current EPSDT program requires a concurrent re-evaluation of the maternal and child health care program.

TUITION INCREASES

Declining federal capitation grants and rising costs are blamed for hefty increases in medical school tuition fees throughout the country. Tuitions average 10% more this year than they did last year, and 50% to 100% more than four years ago. The Association of American Medical Colleges says the average tuition among public medical schools for in-state residents is now $1,319 per year. Private schools charge an average of $5,000, with Georgetown the most expensive at $12,500 a year. Capitation grants fell from $2,000 per student two years ago to $1,050 last year.

* * * *

HOSPITAL ACCREDITATION

The Joint Commission on Accreditation of Hospitals has made some changes in the 1976 edition of the *Accreditation Manual for Hospitals.* There is a new section on standards for rehabilitation programs and services and revised interpretations of standards in sections on governing body and management, medical records, medical staff, and respiratory care. The new and revised standards will become effective for accreditation decision purposes in surveys conducted on or after next April 1.

* * * *

MISQUOTED

Vice President Walter Mondale has told the AMA he was misquoted by a news wire service in a statement on health care costs last summer. Attributed to Mondale was a statement that General Motors pays more for health insurance than it does for steel. For months GM has been trying to make clear that while its health insurance bill is larger than its purchases from U.S. Steel, it buys steel from many companies and its total outlay for steel is much larger than that for health insurance.

PSRO MEMBERSHIP

AMA has reminded Congress that the framers of the Professional Standards Review Organization (PSRO) law five years ago contemplated that PSRO membership be restricted to physicians. AMA pointed out that the law recognizes the use of non-physicians in certain aspects of the program. However, AMA PSRO Chairman John Glasson, M.D., told the House Ways and Means Committee, "that non-physician involvement should be a local PSRO option along the lines expressed in the presently effective PSRO law."

* * * *

NO TESTIMONY

The AMA declined to testify on "the regulatory and competitive aspects of the health care industry" at hearings scheduled to begin in October before two subcommittees headed by Sen. Edward M. Kennedy. In a letter to Kennedy, AMA said legal counsel had advised the Association not to testify because "the issues to be addressed . . . are essentially the same as the issues now in trial before an administrative law judge of the Federal Trade Commission."

* * * *

NHI HEARING

A federal hearing on National Health Insurance legislation has been told that any NHI program should be built "on the many strengths of the present system." William C. Felch, M.D., Chairman of the AMA Council on Legislation, said the objectives must be to assure continuation of the benefits of the present health care system "to all our citizens without impairing its quality or inhibiting its creative energy for continued innovation and improvement. (Edward R. Annis, M.D., Past President of the AMA, testified on behalf of the Florida Medical Association at a similar hearing in Jacksonville last October 6. See November 1977 issue of JFMA, page 773).

* * * *

LOAN DEFAULT

More than 300 employees of the federal Department of HEW have defaulted on government loans to help finance their educations. Together, they owe the government $403,000. Thirty-seven of the defaulters have salaries ranging from $15,500 to $43,923. An HEW official said the employees would receive "a very nice letter pleading with them" to pay back the loans.

* * * *

"UNNECESSARY" SURGERY

The American College of Surgeons has testified at hearings on "unnecessary surgery" before the House Commerce Subcommittee on Oversight and Investigations. ACS Director C. Rollins Hanlon, M.D., said the need for surgical knowledge and skill and the need to consider the cost of surgery "dictate our continued insistence on long and exacting education for surgeons, rather than casual on-the-job training." He added: "Scrupulously careful delineation of privileges based on education, peer appraisal of skills, and certification of specific competence will remain the most reliable basis for appropriately recommended and safely performed operations."

* * * *

FORCED RETIREMENT

Florida Rep. Claude Pepper has credited the AMA for being instrumental in the overwhelming vote (359 to 4) by which the House of Representatives passed his retirement bill. AMA has stated that forced retirement at age 65 is detrimental to health. Pepper's bill would end mandatory retirement for most federal workers and raise the minimum age to 70 for non-federal employees.

* * * *

LEADERSHIP CONFERENCE

"Synergy in Leadership" is the theme for the AMA's 6th National Leadership Conference, January 26-29, in Chicago. Speakers will include Sen. Edward M. Kennedy and former Olympic Star Bob Richards. A general session on the health care systems of Great Britain, Australia, France and Canada is planned, and seminars on federal and state legislation, health planning, and specialty and state society relationships will be offered.

The Editor

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Rodney Bluestone, M.D.
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UCLA

Osteoarthritis
Roland Moskowitz, M.D.
Clinical Professor of Medicine
Case Western Reserve
College of Medicine
Cleveland, Ohio

Gout
Herbert Diamond, M.D.
Professor of Medicine
SUNY Downstate Medical Center

Infectious Arthritis
David Kaplan, M.D.
Professor of Medicine
SUNY Downstate Medical Center

Rheumatoid Arthritis
Charles M. Plotz, M.D.
Professor of Medicine
Chairman, Dept. of Family Practice
SUNY Downstate Medical Center

Rheumatoid Arthritis Variants
Harry Spiera, M.D.
Clinical Professor of Medicine
Mt. Sinai School ot Medicine
New York, N.Y.

Uncommon Rheumatic Disease
Gerson Bernhard, M.D.
Clinical Professor of Medicine
Medical College of Wisconsin

Systemic Lupus Erythematosus
Norman Talal, M.D.
Professor of Medicine
U. California, San Francisco

Other Connective Tissue Disease
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Nonarticular Rheumatism
P. Kahler Hench, M.D.
Senior Rheumatologist
Scripps Clinic, LaJolla, California

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Chief, Medicine Branch
National Cancer Institute

Acute Leukemia
Edward S. Henderson, M.D.
Professor of Medicine
State University of New York at Buffalo

Chronic Leukemias
Richard T. Silver, M.D.
Professor of Clinical Medicine
Cornell University Medical College

Hodgkins and Non-Hodgkin's Lymphomas
Saul A. Rosenberg, M.D.
Chief, Oivision of Oncology
Professor of Medicine and Radiology
Stanford University School of Medicine

Myeloma & Macroglobulinemia
Robert Kyle, M.D.
Professor of Medicine
Mayo Medical School

Breast Cancer
Barth Hoogstraten, M.D.
American Cancer Society
Professor of Medicine
Kansas University Medical Center

Pediatric Tumors
Lucius F. Sinks, M.D.
Professor ot Pediatrics
Georgetown University
Medical Center

Gastrointestinal Cancer
Charles G. Moertel, M.D.
Professor of Oncology
Mayo Medical School

Lung Cancer
Clifton F. Mountain, M.D.
Protessor of Surgery
University of Texas
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Genitourinary Cancer
B. J. Kennedy, M.D.
Professor of Medicine
Masonic Professor of Oncology
University of Minnesota
School of Medicine

Gynecologic Malignancies
M. Steven Piver, M.D.
Clinical Protessor of Obstetrics
and Gynecology
State University of New York at Buffalo

Melanoma
Larry Nathanson, M.D.
Professor of Medicine
Tufts University School of Medicine

Soft Tissue Sarcomas
Steven Rosenberg, M.D.
National Cancer Institute
Oepartment of Surgery
Bethesda, Maryland 20014

Head and Neck Cancer
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LEGISLATIVE NEWS

Legislative Preview - 1978

The 1978 Session of the Florida Legislature promises to be once again an active one in terms of health legislation. More than 400 bills affecting health care are anticipated with a large number of these being of critical concern to Florida's physicians.

Issues likely to be given active consideration include health care cost containment, medical malpractice, workers' compensation revisions, rural health care, Medicaid reorganization, and role and scope of practice for various health professions.

Since the 1977 Legislature adjourned on June 3, 1977, major efforts of the Association have been directed toward passage of a constitutional mandate for a Department of Health. The vehicle for this has been the 37-member Constitution Revision Commission which plans to have a final draft ready by April 18. Among the leading legislators opposing this concept is Sen. Jack Gordon (D-Dade). In his presentation to the Commission on November 15, Senator Gordon stated that:

"Separating health out of the Department of HRS would mean less communication and teamwork and more fragmentation of services to the client. I believe that this reasoning is still valid and will remain valid for many years to come.

"If you will examine the issues and charges relating to the question of physician leadership, I am sure you will find that there are more attempts to protect a special interest group's privileged status than there are sincere efforts to improve human service programs.

"The biggest thing that physicians are in charge of these days is our health care system, a system which presently costs Americans $1 million an *hour,* and I will leave it up to you to judge how well they are doing in keeping us well. I don't believe we need that kind of "leadership" for such an important function of state government."

A very close vote is predicted on the Department of Health concept, with the final outcome dependent upon the active work being carried out by contact physicians and allied health groups at the local level.

Important emphasis is also being placed on legislation to allow recovery of defense costs in malpractice cases. This concept allows for recovery of attorney fees and other costs of defense in those cases where a court upholds a mediation panel's recommendation that the physician is not negligent. It is anticipated that this will reduce the number of frivolous suits and appeals.

Also of interest is the medical incident committee bill (SB 166) filed by Sen. Kenneth MacKay (D-Marion). This bill requires that each health care facility establish a medical incident committee to be composed of "two persons chosen by a majority vote of the medical staff authorized to practice in the establishment, the presiding member of the establishment's governing board or his representative, and one additional person designated by the establishment's governing board." The bill further provides that:

"The committee may recommend that compensation be offered to secure the release of the establishment from liability from a patient sustaining an injury in such establishment, but no offer of compensation shall be made without approval of all parties who may be bound by the offer. No physician or establishment shall negotiate or attempt to secure a release from liability from a patient sustaining an injury in the establishment until after the committee has either notified the patient of an offer for compensation or has decided that no offer will be made. The findings and determinations of the medical incident committee shall not be binding."

Submitted by the FMA Council on Legislation and Regulations.

County medical society legislative chairmen and contact physicians have been provided an informational packet outlining in detail these and other issues of concern to FMA members. It is most important that adequate time and attention be devoted to thoroughly informing legislators as to the FMA's position. When fully informed on the issues, Florida's Legislature can be expected to make decisions that will improve the ability of physicians to deliver quality health care to their patients. There will be no one to blame but ourselves if bad laws are passed because of a lack of adequate input by local physicians.

Your Capital Office is staffed with competent professionals who will provide you with detailed bill analyses and background information. Your Council on Legislation and Regulations has been working hard the past few months to develop a meaningful legislative package and we look forward to a successful 1978 Legislative Session.

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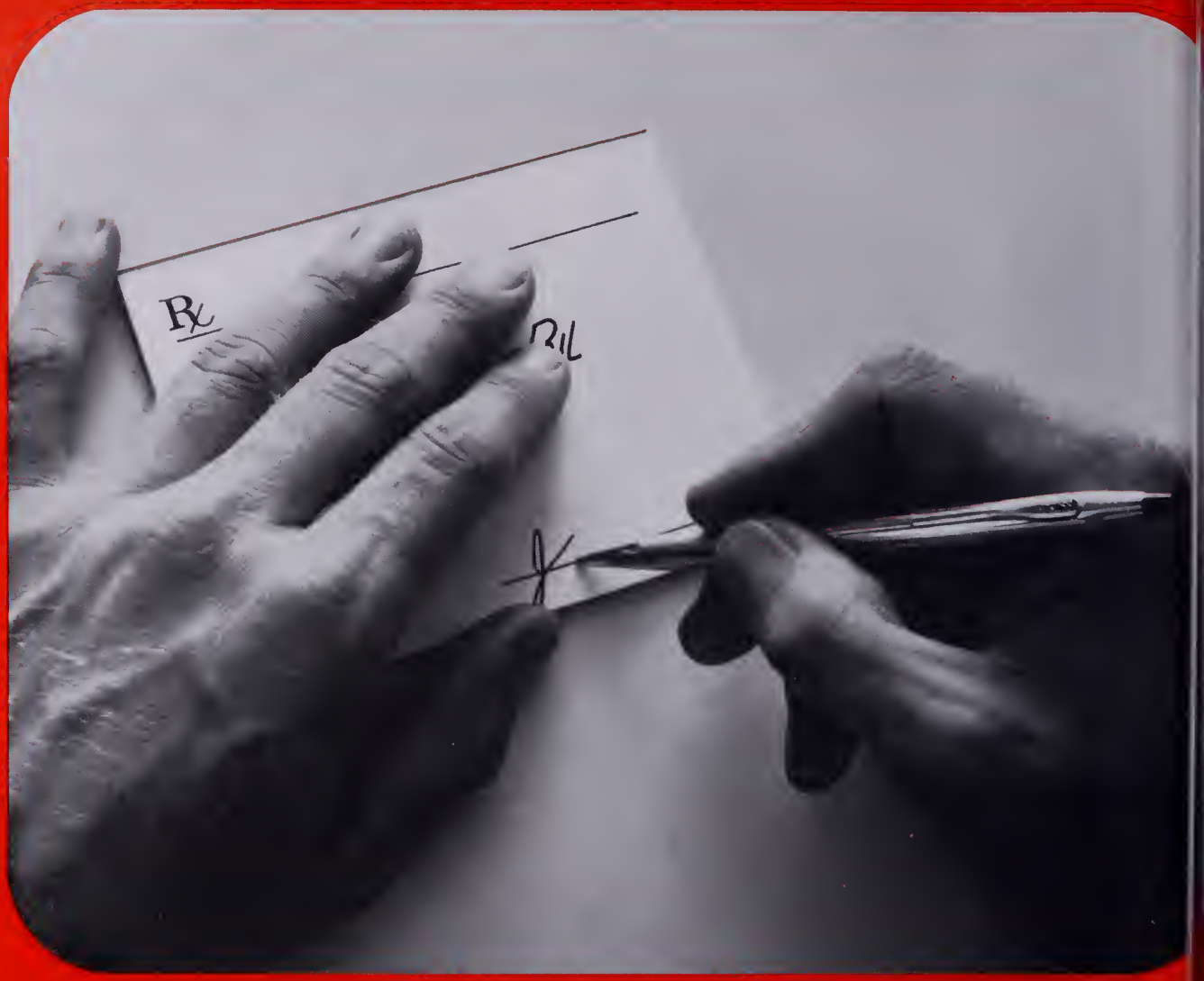
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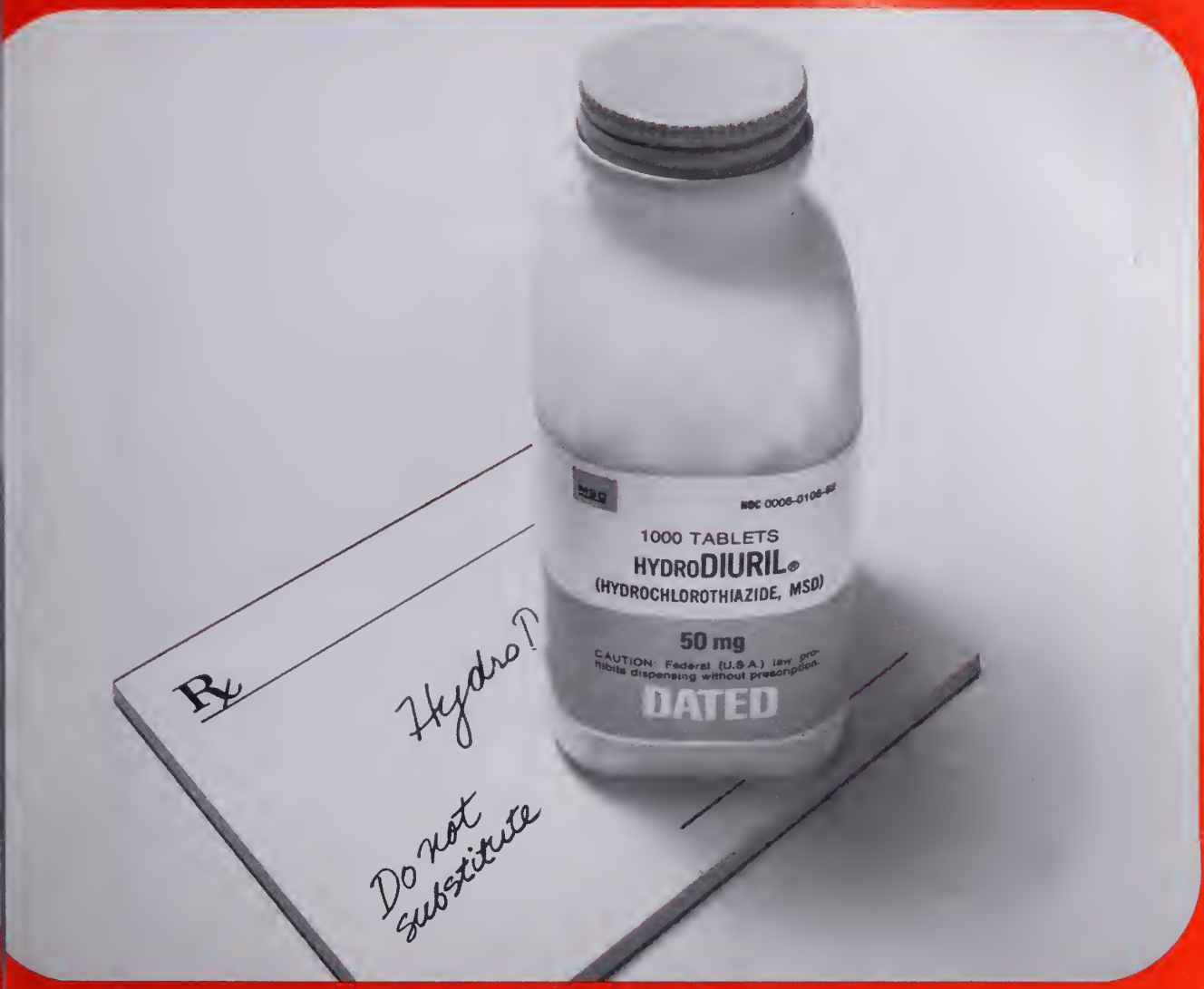
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Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitali may also influence serum electrolytes. Warning signs, irrespective cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness restlessness, muscle pains or cramps, muscular fatigue, hypotensi oliguria, tachycardia, and gastrointestinal disturbances such as na and vomiting. Hypokalemia may develop, especially with brisk diur in severe cirrhosis, with concomitant corticosteroid or ACTH thera with inadequate oral electrolyte intake. Hypokalemia can sensitize exaggerate response of heart to toxic effects of digitalis (e.g., incre ventricular irritability). Hypokalemia may be avoided or treated by of potassium supplements, such as foods with a high potassium c tent. Any chloride deficit is generally mild and usually does not req specific treatment except under extraordinary circumstances (as liver disease or renal disease). Dilutional hyponatremia may occur edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instanc when the hyponatremia is life threatening. In actual salt depletion, propriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in cer patients. Insulin requirements in diabetic patients may be increase decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness t norepinephrine; this diminution is not sufficient to preclude effecti ness of the pressor agent for therapeutic use. If progressive renal

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ment becomes evident, consider withholding or discontinuing
etic therapy. Thiazides may decrease serum PBI levels without
s of thyroid disturbance. Calcium excretion is decreased by
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emia and hypophosphatemia have been observed in a few patients
prolonged therapy; thiazides should be discontinued before testing
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erse Reactions: *Gastrointestinal System*—Anorexia; gastric ir-
ion; nausea; vomiting; cramping; diarrhea; constipation; jaundice
ahepatic cholestatic jaundice); pancreatitis; sialadenitis.

tral Nervous System—Dizziness; vertigo; paresthesias; headache;
hopsia.

natologic—Leukopenia; agranulocytosis; thrombocytopenia;
stic anemia.

diovascular—Orthostatic hypotension (may be aggravated by
hol, barbiturates, or narcotics).

ersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing
itis (vasculitis) (cutaneous vasculitis); fever; respiratory distress
uding pneumonitis; anaphylactic reactions.

er—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm;
kness; restlessness; transient blurred vision.

enever adverse reactions are moderate or severe, thiazide dosage
uld be reduced or therapy withdrawn.

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Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis; history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely establish therefore, do not use extensively on pregnant patients, in lo amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsuscept organisms (including fungi other than candida). Should superin tion due to nonsusceptible organisms occur, administer suitc concomitant antimicrobial therapy; if favorable response is not pror discontinue the preparation until adequate control by other c infectives is effected. If extensive areas are treated or if the occlu technique is used, the possibility exists of increased systemic abs tion of the corticosteroid; suitable precautions should be take irritation develops, discontinue the product and institute appropr therapy.

ADVERSE REACTIONS: Sensitivity reactions to topical use of gramic are rare. Hypersensitivity to nystatin is extremely uncommon. Hy sensitivity to neomycin has been reported and articles in the cur medical literature indicate an increase in its prevalence.

The following local adverse reactions have been reported topical corticosteroids either with or without occlusive dressings: b ing sensations, itching, irritation, dryness, folliculitis, secondary ir tion, skin atrophy, striae, miliaria, hypertrichosis, acneform erupt maceration of the skin, and hypopigmentation. Contact sensitivity particular dressing material or adhesive may occur occasionally. toxicity and nephrotoxicity have been reported.

For full prescribing information, consult package insert.

HOW SUPPLIED: Available in 15, 30, and 60 g. tubes. It is also c able in jars of 120 g. (4 oz.) for hospital or institutional use only.

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Papillary Thyroid Carcinoma Presenting as a Warm Nodule

Jack B. Thigpen Jr., M.D., C. Ted Montgomery, M.D. and Brooks Brown, M.D.

This case is presented to reemphasize the need for consideration of thyroid carcinoma in the "warm" nodule on routine RAI thyroid scans. Messaris et al[1] reported a 6.2% incidence of malignancy in 32 patients presenting with "warm" thyroid nodules.

Case History

This 24-year-old single male maintenance engineer presented with a one month history of a tender mass in the right side of the neck. He denied symptoms of dysphagia or hoarseness and there was no family history of thyroid disease. There was no history of radiation exposure and he was not taking any medications prior to admission.

They physical examination was unremarkable except for a 1 to 1½ cm firm, tender nodule in the inferior portion of the right lobe of the thyroid gland.

The laboratory data revealed normal values for T3, T4, T7, TSH and thyroid antibodies. The I-131 AP thyroid scan demonstrated a normal percent uptake with a homogenous diffuse pattern.

The patient was taken to surgery where following a nondiagnostic frozen section of the nodule a right thyroid lobectomy and isthmusectomy was performed. The permanent pathology sections revealed papillary adenocarcinoma with psammoma bodies and metastasis to a small lymph node removed from the sternal notch area. The patient then underwent the completion of a toal thyroidectomy with preservation of as much parathyroid tissue as possible along with a modified radical neck dissection and superior mediastinal exploration. No additional metastasis were identified. A total body I-131 scan failed to reveal any distant metastasis. The patient was discharged on Cytomel so repeat scans could be easily done prior to permanent thyroxine replacement.

The unusual aspect of this case is the "warm" nodule presentation of a papillary adenocarcinoma of the thyroid. Papillary adenocarcinomas of the thyroid are the most common type of thyroid malignancy prior to age 40 but are rarely "warm" or "hot" on routine thyroid AP scans.[2-5] The consideration of thyroid malignancy in "warm" nodules is not a new idea but this case points out that the idea of only "cold" nodules being malignant should be discarded. The clinical setting still dictates the therapeutic approach. An alternate acceptable therapeutic approach to the management of this case would have been to try suppressive thyroid therapy with close clinical observation. This approach was not chosen because of the single nodule presentation in a male patient. The scanning technique presented here is the AP scan only and certainly normal tissue could be superimposed on a "cold" nodule making it appear "warm." Lateral thyroid scans are not a routine procedure ordered by most clinicians but may show a "cold" nodule not visible on the AP view. Retrospectively, a soft tissue x-ray of the thyroid gland area in this case may have shown microcalcification based on the pathological findings of psammoma bodies. Microcalcification of the thyroid on x-ray is suggestive of malignancy. A soft tissue x-ray of the thyroid gland area is a simple procedure and is recommended to complete the total noninvasive workup of thyroid nodules in any patient. Also, recently, thyroid sonograms have been shown to be useful.

Sincere thanks to Mrs. Nancy Mitchell, Memorial Hospital librarian, for her help.

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Neomycin Ototoxicity Associated with Wound Irrigation in the Local Treatment of Osteomyelitis

Case Report and Literature Review

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Abstract: Although ototoxicity associated with neomycin administration has been experienced and discussed previously, the pathophysiologic basis is less well appreciated. Unlike the ototoxicity of other related antibiotics, that which is secondary to neomycin is progressive, severe and irreversible. Considering the lack of evidence to substantiate its effectiveness in local antibiosis, it is reasonable to avoid the use of neomycin sulfate in irrigation of wounds except for life-saving emergencies.

Severe ototoxicity resulting from the parenteral administration of neomycin has been known for some time.[1] In recent years, there have been reports of deafness associated with the use of neomycin orally,[2] topically,[3] and in irrigation solutions for the mediastinum[4] as well as other wounds.[5,6]

This case is presented because of its severity and irreversibility; as well as to suggest that the use of neomycin as a wound irrigant in orthopedic surgery is dangerous and to be avoided.

Case Report

A 60-year-old Caucasian female was admitted to the hospital for evaluation of a painful right hip.

The previous year she had sustained a fracture of the same hip (Intertrochanteric Fracture Boyd Type II) which had been treated by reduction and Jewett nail fixation. In the interim she had progressed in ambulation to cane-assisted full weight-bearing and was pain free.

For several weeks prior to admission, however, the patient had had increasing pain in and about the right hip. The pain was aggravated by motion and weight-bearing to the extent that she could only perform her housework with difficulty.

Laboratory evaluation showed the patient's ESR 54 mm/hr; hip joint aspiration was positive for pus with E. coli present (later correlated to genitourinary infection with the same organism). X-rays confirmed union of previous fracture but revealed zone of radiolucency surrounding the nail portion of the fixation device. In addition, it had penetrated the femoral head and was causing subchondral acetabular reaction.

At the time of surgery, the femoral nail-plate was easily withdrawn following removal of the screws. The nail tract was lined with a friable reddish-brown granulation tissue; this was removed using a long thin curet. The joint was drained and debrided. Irrigation-suction tubes were then placed in the nail tract and wound, while the fascia lata and skin were closed with nonabsorbable sutures. The irrigation fluid consisted of a triple antibiotic combination in which bacitracin 100,000 U, neomycin 10 grams, and polymyxin B 100 mg were added to each liter of saline. The irrigation-suction was kept patent and functioning for 13 days during which time a total of 9000 cc irrigant was used (90 grams neomycin). Local and systemic signs and symptoms of infection resolved, and the patient rehabilitated to ambulation with walker assistance.

Six weeks following discharge, when she returned to clinic for evaluation, the patient complained of difficulty hearing people talk to her. Within six months she had profound sensorineural hearing loss bilaterally. This was confirmed by audiometry. Repeat evaluations over a period of 18 months revealed she experienced no return of her auditory acuity.

A careful review of the patient's history and the progressive course of her deafness led to the diagnosis of neomycin ototoxicity.

Pathophysiology of Neomycin Ototoxicity

Neomycin is an antibacterial substance produced by the growth of **Streptomyces fradiae**. It is one of a group of aminoglycoside antibiotics known to accumulate in the cochlear fluid.[7] Their concentration in the inner ear and kidneys exceeds that of all other organs, and often exceeds blood levels.[8] Neomycin is more ototoxic than gentamicin, kanamycin, or streptomycin (as given in their decreasing order of ototoxicity).[10] Neomycin causes cochlear damage which is manifest histologically by destruction of both the inner and outer hair cells.[8] It may also block the efferent synapses.[7] This sensorineural ototoxicity has an early and abrupt onset after parenteral administration, whereas following oral administration the onset tends to be delayed, insidious, and yet progressive.[2]

Autosensitization is thought to play a role in many cases of neomycin ototoxicity. Topical neomycin is a common cause of contact dermatitis.[9] It has been available in over 100 different brands of cream, ointments, and sprays. Patients may thus have been exposed unwittingly and be sensitized prior to its administration orally, parenterally, or as a wound irrigant.

Neomycin ototoxicity has occurred after administration by the following routes: parenteral, oral, surgical bowel preparation,[10] wound irrigation, aerosol, cutaneous application, intrapleural infusion, and from neomycin treated porcine skin grafts.[3]

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The amount of neomycin absorbed from a fresh wound surface or a granulating bed varies considerably. If the tissue is vascular however, absorption may be comparable to the absorption from an intramuscular injection site.[11]

The toxic effects of neomycin are not directly related to dosage. While many articles relate total neomycin doses of several hundred grams, the range varies from as low as two grams to as much as 1750 grams.[2] Ototoxicity is more likely in the presence of either renal or liver disease[8] and is enhanced by concurrent use of ethacrynic acid (Edecrin) or furosemide (Lasix).[9] Few studies report blood levels of neomycin, but one case with neomycin ototoxicity was recorded as having a serum level of 105 micrograms/cc.[4]

Neomycin-induced hearing loss may progress for days, weeks, or months after withdrawal of the drug; it is often complete and permanent.[5,8,9] This is in contradistinction to the ototoxicity of related drugs (eg. kanamycin) where hearing loss ceases or even decreases if the drug is promptly discontinued at the first indication of tinnitus or decreased auditory acuity.[6]

Neomycin causes loss of hearing in the extremes of sound first, and only later in the conversation range; thus the patient may not recognize a deficit until after prolonged use of the medication, or even after its use was discontinued. Audiometry is essential to early diagnosis of neomycin ototoxicity.[2]

Wound Irrigation

The orthopedic surgeon's eternal quest for asepsis led him to purge wounds, acute and chronic, surgical and traumatic. This exorcizing involved a variety of medicines and modalities. During the "sixties," an irrigation-suction technic was popularized and promoted.[12-15] The solutions used as irrigants contained any number of combinations with electrolytes, detergents, enzymes, and antibiotics.[12-17] The "seventies" have been a period for re-evaluating the concept and the methods.[18] Antibiotics in the irrigation fluid are probably unnecessary and at most only temporarily useful.[17,19,20] An osmotic and mechanical lavage must be considered its essence.[13]

Still today, neomycin is being advocated as an adjunct to the treatment of both established wound infections and as an aid to surgical aspects.[21-24] The use of neomycin in such situations has not been established to be of therapeutic value. It may sensitize the patient to related drugs which are potentially lifesaving (kanamycin, gentamicin, streptomycin). It may also promote the emergence of bacteria that are resistant to these related antibiotics.[9]

The surgeon must balance the questionable value of local antibiotics against the risk of serious systemic toxicity.[11] The uremia of neomycin toxicity may be reversible; the deafness is not. Even the use of a dilute 0.1% solution yields one gram of neomycin sulfate per liter of irrigant; and neomycin ototoxicity has occurred with a recorded dosage as low as two grams![2]

Summary

A case of neomycin ototoxicity following irrigation of a surgical wound with neomycin sulfate is outlined. The pathophysiology which causes neomycin ototoxicity to be unique, progressive and severe is presented with hope that its use will be discontinued, except for life-saving emergencies.

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Cervical Mucus
A New Dimension for Family Planning

John J. McCarthy Jr., M.D.

Abstract: The introduction of cervical mucus observation as a practical guide to anticipate ovulation has created renewed interest in natural methods of family planning. The basal body temperature graph has established reliability in identifying the postovulatory infertile phase of the menstrual cycle. To gain physician acceptance a natural family planning method must be available and acceptable to patients seeking a method of family planning. It is recognized that the physician cannot devote the time in his office schedule to instruct each individual patient in the method and be assured through follow up that she can use the method. For this reason a paraprofessional must be developed with the attributes necessary to provide the method in a competent manner. The paraprofessional should have medical support in her training, in continuous education, and in providing the method. A well-designed program using paraprofessionals should monitor itself to assure that the highest quality standards in providing the method are maintained.

The natural methods of family planning have experienced a renewed interest from women looking for family planning alternatives. There are a number of reasons. A major one is the timely introduction of the ovulation method into this country about five years ago.[1] The introduction by Drs. John and Evelyn Billings of Australia can be called timely because it appears to fill the void and satisfy some of the objections to the basal body temperature method. It is timely also because it came at a time in this country when accepting one's own body and bodily functions has been emphasized.

Women are taught to become aware of changes in the cervical mucus secretions in order to anticipate the approach of ovulation and identify the postovulatory phase of the menstrual cycle. How can women recognize these changes? They are beginning to challenge this common medical attitude toward themselves. Paraprofessionals trained to assist women in interpreting their cervical mucus testify that most women have distinct sensations of wetness and dryness along with visual observations that enable them to recognize the changes. Not only can the distinct lubricative sensation near ovulation be recognized but also the start of mucus secretion in anticipation of ovulation. Change from the lubricative sensation signals the postovulatory period.

The basal body temperature method (BBT) has well established effectiveness for family planning purposes. The biphasic temperature graph identifies the postovulatory nonfertile phase of the menstrual cycle. Several studies[2,3] have indicated high method effectiveness (1 pregnancy per 100 woman years) when sexual intercourse is confined to this phase.

When the entire menstrual cycle is considered, the BBT method formerly combined calculations used in the obsolete rhythm or calendar method. Depending upon the care taken in recording past cycle lengths, conception rates were at best comparable to the diaphragm as a method for family planning. The occasional unusual cycle accounted for some conceptions while careless assumptions of previous cycle lengths resulted in higher conception rates. Even without considering method effectiveness the critics realistically observed that the long-cycled woman, the lactating woman, the postpartum woman and the perimenopausal woman, all had long delays in recognizing the temperature shift which signaled the postovulatory phase of the menstrual cycle. These objections limited the usefulness and acceptability of the BBT method combined with calculations for preovulatory days. The need for a direct guide to replace calculations to determine preovulatory nonfertile days in all types of cycle circumstances has been obvious for many years. The introduction of the use of cervical mucus (CM) observations thus gained immediate recognition as the possible solution to making natural family planning methods acceptable to more couples.

The study of the infertile couple is directing more attention to cervical mucus. An excellent review related to spermatozoan transport in cervical

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mucus by Davajan[4] cites evidence of alterations in cervical mucus composition that directly relates to sperm penetration of the mucus. The favorable characteristics of "mid-cycle" cervical mucus are well documented. Numerous investigators[5,6] have attempted to standardize the assessment of cervical mucus with a cervical score emphasizing the same characteristics. Several in vitro studies[7,8] exposing cervical mucus samples to uniform samples of semen have demonstrated the relationship of low cervical score to poor sperm penetration. The relationship between cervical mucus and sperm penetration demonstrated in these studies strengthens the case for cervical mucus observations as a family planning method. The value of the BBT graph to confirm the postovulatory infertile phase of the cycle has been documented. CM observations may be used alone as the ovulation method or may be combined with the BBT graph in making natural family planning methods a true choice for family planning.

In spite of a renewed interest sparked by the application of CM observations, the methods may be difficult for women to obtain due to the unavailability of proper instruction. The physician who recognizes women who might select this type of family planning might ask the question, "Can I afford the time to individually instruct this woman in my office?" The answer to this is usually NO! Yet, self-teaching should not have a place in providing any family planning method. This physician should be able to turn to a paraprofessional who can provide the patient with professional instruction and supportive follow up.

WHAT CAN A PHYSICIAN EXPECT WHEN A PATIENT IS REFERRED TO A PARAPROFESSIONAL FOR A SERVICE?

The paraprofessional is well trained to provide the family planning method under consideration.

Many feel, and I share this opinion, that the paraprofessional should be a woman who has a positive attitude toward the chosen method. Given such a woman, or in many cases a couple who is interested in providing the method, the next important element is thorough training. The paraprofessional is going to be instructing women who may differ greatly from her own cycle pattern. She therefore has to have a good background in reproductive physiology as well as the method. In considering certification of a paraprofessional not only her knowledge of the method but her communicative abilities have to be considered. A good program in continuing education is essential for any paraprofessional to maintain proficiency.

The paraprofessional has qualified professional back up.

A physician with a positive attitude toward the method should be part of the training and continuous education program. In addition the paraprofessional needs a resource for consultation—a physician well versed in the method. Frequently a very experienced paraprofessional would serve as the primary back up to others.

A professional relationship with the referring physician is maintained.

The referring physician should be notified that the patient has received instruction in the method. When the patient has medical problems related or unrelated to the method, she should be advised to consult the referring physician. A physician responsible to support the paraprofessional should maintain a consulting role with the paraprofessional and the referring physician. When the paraprofessional is satisfied that the patient is competent in using the method for family planning, a summary report should be sent to the referring physician. The referring physician should be immediately advised when a patient for any reason is not able to use the method for family planning.

The patients are individually managed for their own needs with high standards of confidentiality.

The term "patient centered care," is frequently used to indicate that the patient's needs and convenience are of primary concern in designing a program for patient care. The response to questions and chart interpretation should be immediate. The entire patient contact should have the medical orientation to confidentiality.

The performance of each paraprofessional and of the overall program is monitored.

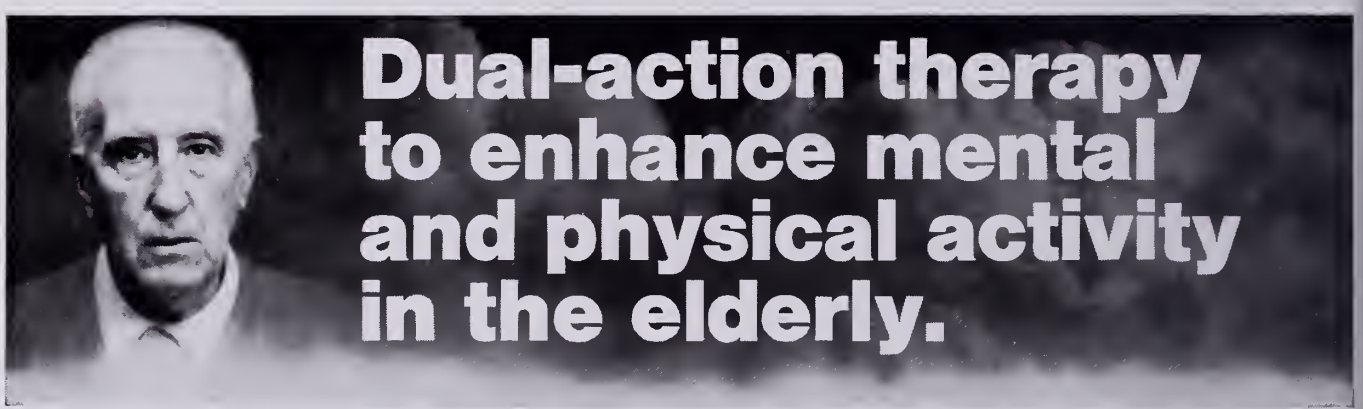
To provide a method of family planning and to be assured that it is provided in a competent manner, some method should be adopted to assure constant monitoring. The quality of charts for a natural method may serve as one measure of the competence of instruction and follow up. Certainly patient satisfaction and continuation with the method is another measure. Pregnancy rates alone cannot tell the whole story of the success of the program. Rates nevertheless should be known in order to help the paraprofessional understand the method and user components. If the method is chosen and used by an increasing number of women, this can be another measure. While there may be cultural differences, there should be some uniformity in the performance of individual paraprofessionals or programs. If not, why?

Many women will choose a physiologic means of family planning if it is provided in a professional way. If provided in a haphazard fashion, however, it will soon develop a reputation of being ineffective. Family planning is a serious matter! Programs need physician involvement to insure quality service.

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PROGRAM

"CONSULTATIONS IN CLINICAL GASTROENTEROLOGY"

FEBRUARY 28 - MARCH 1, 1978

Tuesday morning, February 28 — Moderator: G. Gordon McHardy, M.D.

8:00 AM	Registration	Louis E. Wolfson Auditorium Lobby
8:30- 9:00	Antibiotics in Gastrointestinal Disease	K. Ratzan, M.D.
9:00- 9:30	Motility Disturbance of the Esophagus	C. Espiritu, M.D.
9:30-10:00	Ulcer Therapy: New and Old Tradition	G. McHardy, M.D.
10:00-10:15	Coffee Break	
10:15-10:45	Therapeutic Endoscopy	S. Kaplan, M.D.
10:45-11:15	Irritable Colon and Diverticular Disease	A. Rogers, M.D.
11:15-11:45	Panel Discussion: Drs. McHardy, Ratzan, Espiritu, Kaplan, Rogers	

Tuesday afternoon, February 28 — Moderator, Allan A. Kaplan, M.D.

1:30- 2:00	Drug-Induced Liver Disease	C. Espiritu, M.D.
2:00- 2:30	Spectrum of Chronic Hepatitis	E. Schiff, M.D.
2:30- 3:00	Acute Cholangitis	A. Kaplan, M.D.
3:00- 3:30	Cholestasis	E. Schiff, M.D.
3:30- 3:45	Questions and Answers	

Wednesday morning, March 1 — Moderator: Martin H. Kalser, M.D.

8:30- 9:00	The Medical Management of Ulcerative Colitis and Crohn's Disease. Results of the Long Term Trial of 6-Mercaptopurine Therapy	B. Korelitz, M.D.
9:00- 9:30	Systemic Manifestations of Chronic Inflammatory Bowel Disease	W. Ludwig, M.D.
9:30-10:00	Toxic Megacolon	F. Tedesco, M.D.
10:00-10:15	Coffee Break	
10:15-10:45	The Surgical Management of Ulcerative Colitis and Crohn's Disease with Considerations of Recurrent Ileitis	B. Korelitz, M.D.
10:45-11:15	The Continent Ileostomy	M. Goldsmith, M.D.
11:15-11:45	Panel Discussion: Drs. Kalser, Tedesco, Ludwig, Korelitz, Goldsmith	

Wednesday afternoon, March 1 — Moderator: Arvey I. Rogers, M.D.

1:30- 2:00	Update Pancreas	J. Barkin, M.D.
2:00- 2:30	Non-Invasive Techniques in Diagnosis of Pancreatic Disease	M. Viamonte, Jr., M.D.
2:30- 3:00	Surgical Treatment of Chronic Pancreatitis	F. Ackroyd, M.D.
3:00- 3:30	Diagnostic Approach to Malabsorption Syndrome	A. Rogers, M.D.
3:30- 4:00	Panel Discussion: Drs. Barkin, Ackroyd, Viamonte, Rogers	

Course Description:

This course is directed towards the practicing physician and surgeon in the specifics of diagnosis, treatment and practical application of the most recent advances in gastroenterology. Sufficient time will be allotted for the panel discussions and question and answer periods for the registrants to confer with the faculty.

CARMELITA R. ESPIRITU, M.D.
PROGRAM DIRECTOR

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Betagole, Samuel L., Miami; born 1892; Northwestern University, 1922; member AMA; died October 27, 1977.

Bryant, James M., Jacksonville; born 1891; Emory University, 1915; member AMA; died August 25, 1977.

Christensen, Louis N., Seattle, Washington; born 1906; Loma Linda University, 1936; member AMA; died September 15, 1977.

Drohomer, Peter A., Daytona Beach; born 1902; Emory University, 1934; member AMA; died October 28, 1977.

Gorday, Abraham J., St. Petersburg, born 1914; University of Illinois, 1936; member AMA; died October 28, 1977.

Halpern, Sidney, Jacksonville; born 1912; Jefferson Medical School, 1937; member AMA; died October 4, 1977.

Koenig, Alfred D., St. Petersburg; born 1916; University of Lausanne, 1942; member AMA; died November 16, 1977.

Mease, John A. Jr., Dunedin; born 1897; Medical College of Virginia, 1923; member AMA; died September 6, 1977.

Mickley, John H., Fort Lauderdale; born 1907; University of Maryland, 1932; member AMA; died October 22, 1977.

Scarborough, Chaffee A., Miami; born 1902; Medical College of Virginia, 1934; member AMA; died October 31, 1977.

Sheridan, John J., Fort Lauderdale; born 1922; Georgetown Medical School, 1947; member AMA; died June 17, 1977.

Tilles, Samuel, Hollywood; born 1904; Temple University, 1931; member AMA; died July 5, 1977.

Valdes, Eduardo O., Tampa; born 1905; Havana University, 1928; member AMA; died October 3, 1977.



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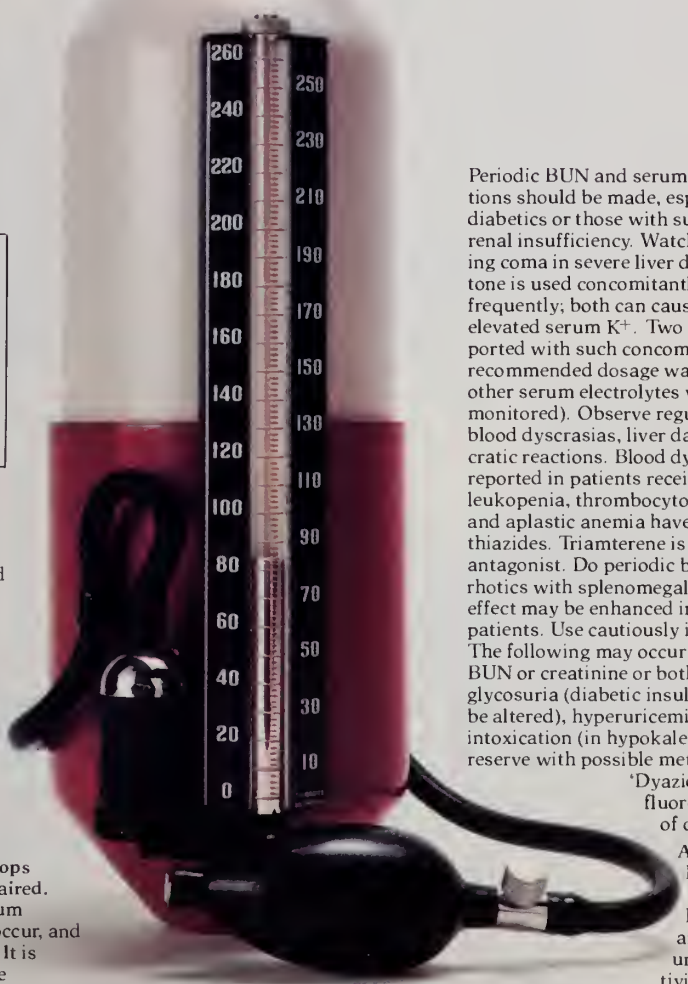
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SPECIAL ARTICLES

Health Service Used By North Florida Medicaid Recipients

Richard C. Reynolds, M.D., Phyllis R. Bleiweis, M.A., Sam A. Banks, Ph.D., and Neil A. Butler, M.N.

ABSTRACT: Two hundred fifty-nine Medicaid recipients in a north Florida county (Alachua) were asked about their perceived health status, utilization of health care facilities and knowledge of Medicaid benefits. Seventy-three percent had seen a physician within the year prior to the interview. State health personnel estimate that fewer than 40% of the private practice physicians in the county accepted Medicaid, indicating most of the recipients received care in the public sector. Forty-seven percent of the recipients reported use of the county sponsored adult and pediatric clinic. Alachua County Medicaid recipients and Florida Medicaid recipients make a comparable number of physician visits per person per year (1.89 visits and 1.25 visits respectively), far less than the national average of 4.9. Only 22% of the Alachua County Medicaid recipients saw a dentist in the year prior to the study. This is one half the Alachua County population average but comparable to the National Health Survey sample with an income under $2,000. Hospital care, physician services and prescription drugs were recognized as Medicaid benefits. The majority of the recipients did not know other services were available to them.

In 1965 the enactment of Title XIX of the Social Security Amendments established the Medicaid program. Its purpose was to make health care more accessible to the poor citizens of the United States. Federal grants were made to states who also committed some of their funds toward this goal. The federal government established guidelines for state eligibility as prerequisites for receiving Medicaid money. Each state plan had to include as a minimum: inpatient hospital services, outpatient hospital services, laboratory and x-ray services, nursing home services, and physicians' services. Other provisions remained optional until 1969 when screening and diagnostic follow-up were added for Medicaid eligibles under age 21. Home health services were added in 1970 and in 1972 family planning became an obligatory service provided by all state Medicaid programs.

Eligible citizens for a state Medicaid program include the categorically indigent, that is, the aged, blind, poor families with dependent children, and the permanently and totally disabled. Medically indigent citizens, as defined by the individual states, were also eligible for benefits.

Each state evolved its own version of Medicaid. Some were generous in the definitions of eligibles and provision of health services; others conservative. Since the program was initially intended to yield to the health vendors their usual and customary fees for services, the states were concerned about the costs of the program. Significantly less attention has been directed, however, at utilization characteristics of beneficiaries of this health care program. How often and what kind of services do the eligible citizens obtain through Medicaid? What do they know about its benefits? How does the utilization of health care services by the Medicaid constituents compare to utilization by other population groups? For most programs these questions go unasked.

Dr. Reynolds, Mrs. Bleiweis and Mr. Butler are associated with the J. Hillis Miller Health Center, University of Florida, Gainesville. Dr. Reynolds is Professor and Chairman of the Department of Community Health and Family Medicine, Mrs. Bleiweis is an Assistant and Mr. Butler an Associate in the same Department. Dr. Banks was Associate Professor of Community Health and Family Medicine. He is now President of Dickinson College.

The responses to these questions will vary according to the individual, state plan, and availability and accessibility of health care providers.

The state of Florida initiated its Medicaid program in 1970 at an annual cost of approximately $100,000,000. Today the program spends $250,000,000 a year to serve over 400,000 citizens, all of whom are categorically indigent. There have been no attempts to provide services for the medically indigent. Whenever there has been danger of overspending the budget, services have been curtailed or reimbursement of vendors has been reduced. During one brief, critical time physician fees were established at 15% of the 75th percentile of their "usual and customary" charges. However, this was never implemented.

Methods

The purpose of this study was to explore the impact of Medicaid on the health care behavior of a sample of Medicaid beneficiaries in a north Florida county and to examine their knowledge of the Medicaid program.

Two hundred and fifty-nine recipients of Medicaid benefits (or a spouse or guardian of a recipient) in Alachua County were interviewed between October 1973 and October 1974. This amounted to 5% of all recipients enrolled in the county. The Division of Family Services of the Florida Department of Health and Rehabilitative Services provided randomly selected lists approximately every three months (four lists) from the files of Region III (North Central Florida) Medicaid eligibles. Approximately half the respondents were eligible as members of the Aid for Dependent Children program, and the remainder were from the categories of the aged, blind, or permanently or totally disabled. Rural and municipal families were interviewed in proportion to the population of the county. Alachua County is 30% rural.

All participants were notified of the character and confidentiality of the proposed interview by letter and telephone prior to receiving an appointment. Interviews were conducted in the respondents' homes. Fewer than 2% of those contacted refused to be interviewed.

The five interviewers included a research associate and a research assistant in the Department of Community Health and Family Medicine and three graduate sociology students from the University of Florida. They were instructed to interview an adult in the family who was either a Medicaid recipient or responsible for a Medicaid recipient. An estimation

Table 1. — Demographic Characteristics of 259 Households with Medicaid Recipients.* N=259

	Number	Percent	Mean
Adults in Household			1.9
1 person	122	47.1	
2 persons	77	29.7	
3 or more	59	22.8	
Not answered	1	.3	
		99.9	
Children in Household			2.4
None	43	16.6	
1 - 3	141	54.4	
More than 3	56	21.6	
Not answered	4	1.5	
Not applicable	15	5.7	
		99.8	
Race			
Black	206	79.5	
White	53	20.5	
		100.0	
Sex			
Male	31	11.9	
Female	227	87.6	
Not answered	1	.3	
		99.8	
Age			
19 and under	11	4.2	
20 - 29	59	22.7	
30 - 39	56	21.6	
40 - 49	34	13.1	
50 - 59	33	12.7	
60 - 69	15	5.7	
70 and above	38	14.6	
Don't know	4	1.5	
Not answered	9	3.4	
		99.5	
Marital Status			
Single	57	22.0	
Widowed	63	24.3	
Separated	71	27.4	
Divorced	29	11.2	
Common Law	5	1.9	
Married	34	13.1	
		99.9	
Employed			
Yes	101	38.9	
No	156	60.2	
Not answered	2	.7	
		99.8	
Spouse Employed			
Yes	13	5.0	
No	37	14.2	
Not applicable	190	73.3	
Not answered	13	5.0	
Don't know	6	2.3	
		99.8	
Education			
Less than 8 years	82	31.6	
Some high school	93	35.9	
H.S. or trade graduate	53	20.4	
Some college	13	5.0	
College graduate	3	1.1	
Not answered	9	3.4	
Don't know	6	2.3	
		99.7	

*Sums of these percentages may differ from 100% due to rounding error.

was made by the investigators (on the advice of administrators in the Division of Family Services) that among all the people included in the households involved in the study, at least 80% were Medicaid recipients. That is, of the 999 people in the 259 families interviewed, approximately 800 were Medicaid beneficiaries. Unfortunately not all household members knew if they were eligible for Medicaid. All interviews were discarded where reliability of the respondent was strongly questioned.

A questionnaire of 125 items was prepared. Many of the questions had been used in earlier surveys of other constituencies, two of which were citizens of Alachua County and migrant farmworkers of the St. Johns River Basin in northeast Florida. Responses to the interview were coded, computed and analyzed. Statistical analysis included frequency histograms and chi square comparisons.

To pretest the questionnaire, 38 Medicaid names were selected from the patient roster of the Northeast Volunteer Community Health Clinic in Gainesville. Thirty two agreed to participate in the interview. Subsequently only a few changes were made in the questionnaire. None of these interviews was included in the final report.

Results

The Medicaid population of Alachua County (Table 1) is predominantly black (79.5%), female (87.6%), unmarried (86.9%) and has little formal education. Over 70 percent have not completed high school. Sixty percent are unemployed. Among the 259 individuals interviewed, 46 or 18.4% were 70 years of age or older.

The number of children living in households which were studied ranged from zero to nine. Although the average number of children per household was 2.4, among these households with children, 54 had two, 52 had three, 26 had four, 10 had five, 11 had six, and one each had eight and nine children. Sixteen percent of the households with two or more occupants had no children. One hundred and twenty two, or 47.1%, of those interviewed resided in single member households.

Perceived Health Care Status

All respondents were asked seven questions which subjectively characterized their functioning health status. These questions and the responses are presented in Table 2. The range of responses is narrow. Twenty four to 39% of the population indicated that their health status was poor, was worsening or was interfering with their work or usual activity.

Thirty-nine percent of the population gave negative responses to all seven questions, indicating that the perception of their health status was good. Among the remainder, 25% gave positive answers to four or more questions.

In addition, the responses to five of these questions by a sample of the entire population of Alachua County are included in Table 2. The increased sense of bad health by the poor population of this county is marked.

Table 2. — Perception of Health Status.

Health Status Indicator	Medicaid Population N=259	Alachua County Population N=1645
	Percent Distribution	
Feels present health status is poor	27.8	4.3
Feels health status is worse or much worse than a year ago	22.8	11.9
Feels health status is worse or much worse than five years ago	39.0	23.5
Has often had to go easy on work because of ill health	27.4	8.0
Has been unable to work in the past year because of ill health	37.5	data not available
Has had to miss more than three weeks of work or usual activity because of ill health during the past year	24.3	data not available
Seldom or never feels healthy enough to carry out the things they would like to do	28.2	5.5

Utilization of Health Care Facilities and Providers

The Medicaid beneficiaries were asked to indicate what type of health care provider they consulted. The results are recorded in Table 3. The responses of the Medicaid population are compared to two other groups. The heads of households of migrant farmworkers were interviewed in 1973 in a study of health care needs of migrant workers in three north Florida counties. Alachua County residents (70% of whom live in Gainesville) were studied in 1970.[1] Nearly 73% of the Medicaid patients state that they had seen a physician during the past year. This figure no doubt represents some duplication since the survey instrument did not specify only physicians seen in their offices. The 73% probably includes physicians seen at clinics and hospitals as well. This figure is comparable to the 80% of Alachua County residents who had seen a physician in one year, and similar to the 72%

Table 3. — Use of Health Care Facilities and Providers By Population Groups During One Year.

Agency	Alachua County Medicaid Recipients 1974 N=259	St. Johns River Basin Farmworker Heads of House (1973) N=291[b]	Sample of Alachua County Residents (1970) N=1645[1]
	Percent Distribution		
Medical Doctors[a]	72.9	47.4	80.3
Public Health Nurse	33.6	28.2	3.7
Health Clinic	47.1	39.8	12.6
Hospital Inpatient	19.7	10.3	30.0
Community Mental Health Center	5.8	.003	0.8
Faith Healer or Spiritualist	5.8	.003	1.6
Psychiatrist or Psychologist	6.5	.003	5.1
Social Worker	67.5	4.1	5.9

[a]National Health Survey national average is 72.6% (1972).[2]
[b]The Health and Health Care Needs of Migrant Agricultural Farmworkers in Three Rural North Florida Counties, HSMHA Contract No. PHS-NSA-105-74-42.

recorded in the National Health Survey.[3]

In Alachua County, because of the presence of the academic health center, which includes a teaching hospital and Veteran's Administration Hospital, there is one doctor for every 250 residents. The citizens of the county do not have access, however, to many of the doctors. Of the physicians in private practice it is estimated by county Medicaid administrators that fewer than 40% participate in the Medicaid program. Alachua County sponsors an adult and pediatric clinic for its medically indigent constituents which was used by 47% of the study population. The central office of the North Central Florida Community Mental Health Center is in Gainesville. This was identified by 6% as a source of health care. A similar percentage of respondents also sought care from a provider such as a faith healer or spiritualist. Probably most of the 6.5% who stated they saw a psychiatrist or psychologist did so at the Community Mental Health Center.

Traditionally the public health nurses have served the poor population. One third of the surveyed Medicaid group recalled a visit from the public health nurse during the previous year. Two thirds of the Medicaid recipients had consulted with a social worker. This is accounted for in part by the Division of Family Services' employment of social workers to administer the Medicaid program.

Dental Visits

In Table 4 there is assembled the percent of various groups who indicated they had visited a dentist at least once during the previous year. Altogether 22% of the Medicaid sample had seen a dentist. This was less than one half of the percentage of Alachua County residents who had seen a dentist in one year[1] and comparable to the sample of the national population adjusted for low income.[4] The migrant farmworkers, by nature of their rural location and transiency, have less access to a dentist and visit one significantly less than the majority of the Medicaid population. The 2.3% of the total Florida Medicaid population represented only those under age 20 who saw a dentist.

Table 4. — Visits to the Dentist During Previous Year.

Population Samples	Percent Distribution
Alachua County Medicaid Recipients	22.4
Eligible Florida Medicaid Recipients (1973-74)[a,b]	2.3
Alachua County Residents (1970)[1]	51.6
St. John Sample (1973)[c]	13.3
National Sample (1974)[3]	49.3
National Sample by Income (1969)[4] Under $2,000	26.6

[a]Children through age 20.
[b]Service offered through Medicaid's Early Periodic Screening, Diagnosis and Treatment Program.
[c]The Health and Health Care Needs of Migrant Agricultural Farmworkers in Three Rural North Florida Counties, HSMHA Contract No. PHS-NSA-105-74-42.

Physician Visits

An effort was made to determine the number of times each year a Medicaid eligible person visited a physician and to compare this with other groups. These data are presented in Table 5. Little difference exists (1.89 vs. 1.25 visits per person per year) between Alachua County Medicaid recipients and those from Florida at large in estimated annual physician visits. The remaining data depict little variation among the total number of annual physician visits despite the variation in patient constituency. There is a decrease in physician visits by migrant farmworkers and household members, but the range of annual numbers of physician visits by the other population samples is 3.8 to 4.9.[5]

Table 5. — Physician Visits Per Person Per Year For Selected Population Samples.

Population Samples	Number of Visits Per Person Per Year
Alachua County Medicaid Recipients	1.89[a]
Florida Medicaid Recipients (1973-74)	1.25[b]
Alachua County Residents (1970)	4.7
St. Johns River Basin (Florida) Farmworker Heads of House (1973)[c]	3.5
St. Johns River Basin (Florida) Farmworker Household Members (1973)	2.8
National Health Survey Sample (1971)[5]	4.9
National Sample: Nonwhite	4.4
National Sample: Under $3,000 Income Per Year	6.2
National Sample: South	4.8
National Sample: Outside SMSA's — Farm	3.8
National Sample: 5-8 Years of Education	4.6

[a]This figure is obtained by dividing the number of visits per family by the mean number in each family.
[b]Given the estimated figure of 400,000 persons on Medicaid at any one time during FY 1973-74.
[c]The Health and Health Care Needs of Migrant Agricultural Farmworkers in Three Rural North Florida Counties, HSMHA Contract No. PHS-NSA-105-74-42.

Knowledge of Medicaid

The use of Medicaid by eligible persons is related to their knowledge of this program. Each person was asked questions to ascertain his familiarity with the Florida Medicaid Program. Among those interviewed, 98.5% had heard of Medicaid, and 86.9% had used, at some time, health services provided by this program. Although all interviewed were presently receiving Medicaid benefits, 68.8% did not know who could receive benefits from Medicaid. Fourteen percent thought everyone was eligible, 29.3% were correct concerning eligibility, and 25.5% thought anyone medically indigent could receive benefits. Medical indigency is not a qualification for eligibility in Florida.

In Table 6 there is presented the responses of the study population to specific questions concerning their knowledge of the Medicaid program. Those health services used most often were recognized as a Medicaid benefit by most of the respondents. This includes hospital care, physician services and prescription drugs.

While 73.7% of the respondents know that Medicaid provides for physician services, only 55.2% believe they can use Medicaid benefits in a private doctor's office.

Seventy percent did know where to seek information about eligibility for the Medicaid program. This was correctly identified as the Division of Family Services, or by the older nomenclature, the State Welfare Office.

Table 6. — Recipients Knowledge of Services Provided by Medicaid.

Service	Percent of Recipients Who Think Medicaid Does/Does Not Provide Service
Service Not Provided	
Non-prescription Drugs	66.8
Services Provided	
Prescription Drugs	4.3
Hospital Care	19.3
Physician's Service	26.3
Laboratory and x-ray	58.7
Nursing Home Care	74.1
Home Health Care	78.4
Family Planning	70.7
Transportation	79.5
Screening	56.0

Discussion

Medicaid was introduced to lessen the economic impediments between the poor citizens and the health care provider. Ideally the success of any health care program would indicate that the beneficiaries are healthier and more productive in some

measurable fashion as a result of the program. Such clearcut outcomes, however, are difficult to measure. As a result the investigator often studies processes of health care delivery that reflect change in behavior or attitude of the program recipient toward health care.

The characteristics of the Medicaid population of Alachua County reveal no surprises. The eligibility requirements established by the state of Florida define a poor, black, female, unmarried, unemployed and undereducated population. The perception of present health status as poor or worsening is several-fold greater than that for other citizens of Alachua County. The Medicaid population receives a good portion of their health services from public health nurses and hospital clinics established to serve the indigent.

Although most of the people served by Medicaid had some knowledge of the program, over two thirds had incorrect information. Over 50% also believed they could not use Medicaid benefits in a private doctor's office.

A study of Baltimore Medicaid recipients in 1968-69 revealed that they were the highest users of health services in that community. They saw physicians more often, were admitted more frequently to hospitals and stayed longer than other residents of Baltimore.[6] In 1967-68, the Kaiser program in Portland, Oregon, extended its prepaid group health care plan to 1,200 families that met Office of Economic Opportunities eligibility criteria. This impoverished group of citizens were compared to other members under age 65 of the Kaiser Health Plan. The OEO membership had 11.5% greater number of doctor visits per 1,000 members and 14% more hospital days.[7]

The utilization of health services involves the definition of need by the user, his ability to come in contact with the provider of health care, his access to the provider once he is there, and the attitude and capability of the provider toward the individual seeking his services. The provider can represent either a single physician, group of doctors, multispecialty clinic, hospital emergency room, mental health center or any other person or unit engaged in dispensing health services.

Alachua County, site of a College of Medicine, teaching hospital, Veteran's Administration Hospital and two community hospitals, has by any standard a surfeit of health providers. Nevertheless, the recipients of Medicaid are receiving fewer health services than other local residents. This probably represents an amalgam of factors including a different definition of health needs by poor citizens, inability to engage health practitioners, and hesitation on the part of some providers to serve the Medicaid beneficiaries.

The conclusion is simple. A health care program directed primarily at removing the economic barriers between the poor and health providers is by itself not successful. Until Title XIX is revised or replaced, however, improvements should be made to facilitate easier access to the health care system wherever possible.

Improvements can be made in two directions. Medicaid beneficiaries need to be made more aware of the benefits of the program and the resources available to them. At present they receive little information of an educational nature specifically about the Medicaid program. There is a brochure outlining eligibility and benefits but according to the respondents in this study few people are aware of it. It is only when medical care is necessary that inquiries are made about specific benefits. This means the Medicaid eligibles in this county rarely, if ever, understand the whole program.

Secondly, improvements can be made in the direction of the provider. The problem of Medicaid program acceptance by private practice physicians was not included in this study. It should be investigated further and the results of these investigations used to create means for increased participation by health providers.

The authors gratefully acknowledge the help of Sara Kenaston and Marilyn Uelsmann of the Florida Division of Family Services who provided information on Florida Medicaid and Dr. Ronald Marks of the University of Florida Division of Biostatistics who assisted in analysis of the data.

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Continuing Medical Education In a Community Hospital

An Innovative Approach

Frederick Firestone, M.D. and D. Robert Howard, M.D.

ABSTRACT: Over a 4-year period, a continuing medical education program for family physicians was developed and tested in a community hospital setting. The "program" consists of three basic monthly elements: case/problem oriented seminar, luncheon conferences, quiz hour. The attendance and expressed interest appear to be related to participation and input of the physicians for whom each element was intended. The structure of the program was based on various considerations including accessibility to and acceptability by the physician and to relevancy of material discussed to the daily practice of medicine.

The physicians were provided a means of continuing input into all aspects of the program and, indirectly, supported the minimal related costs. Although attendance varied significantly among the basic program components and was directly related to the nature of the material covered, the overall participation was excellent and averaged 40% of the physicians involved.

One or all the program elements could be readily implemented in other community hospital settings to provide a meaningful postgraduate educational opportunity for members of the medical staff and others who participate in the delivery of health care services.

Program Structure and Organization

The educational "program" is comprised of three basic components — a problem/care seminar, two luncheon conferences (at each of two geographically separated ambulatory care centers) and a "quiz hour" — organizationally linked by a specific communication packet.

The first element of the program is structured around the monthly, family practice oriented seminars which are held at the hospital. Each seminar, which is conducted by a knowledgeable specialist from one of the other departments, involves illustrative case problems which are presented by the guest teacher and supplemented with discussion by the participants. Depending on the topic and the speaker, the seminars are generally attended by 20% to 60% of the practicing family physicians.

The second major element includes luncheon conferences presented monthly at each of two of the larger affiliated ambulatory care centers where many of the family physicians practice. This facet of the program was included in order to bring continuing medical education to the physicians. The luncheon sessions emphasize a traditional discussion format, appropriately augmented with audiovisual aids and material. In order to insure maximum participation the luncheon meetings are planned in detail. Each physician is requested to sign an attendance slip to document his attendance.

The third element is a monthly "quiz hour" held at the hospital and attended by both family practice residents and practicing physicians. At these sessions multiple choice questions, which are previously distributed to all the members, are reviewed and answers are covered in detail.

The communication packet which is mailed to all potential participants includes:

1. A letter of invitation which specifies the topics to be discussed, names of speakers, and times, dates, and locations of each component.
2. A series of case problems to be discussed as part of the seminar session.
3. A 21 question self-study quiz, which the participants are encouraged to complete and return unsigned.
4. The answers for the previous month's quiz.
5. A check-off form to specify plans for attendance (to assure availability of adequate handouts of supplemental information and to arrange the luncheons).

Prescribed credit by the American Academy of Family Physicians and/or Category I continuing

medical education credit by the American Medical Association is obtained for any or all the components of a program structured and organized in this manner.*

Additional Attendance

Also invited to participate in this program were nurse clinicians, social workers, other specially trained nurses, physicians' assistants and family practice residents and medical students who rotated through LaGuardia Hospital as part of a program which is affiliated with Downstate Medical Center.

This group varied in attendance according to the program presented. Physicians' assistants, nurse clinicians and social workers attended primary care subjects more frequently and were able to participate in the discussion.

Speaker Selection

Much of the success of the monthly seminars and luncheon conferences was due to the screening of prospective speakers. The topic to be covered is discussed in detail with the speaker prior to the meeting. The importance of reviewing the specific components with speakers and the selection of interesting speakers cannot be over-emphasized.

Interdepartmental Participation

By experience, it was found that joint seminars presented with other departments provided a way to increase attendance and foster interdisciplinary relationships. Examples of successful ventures of this type included a joint meeting with internal medicine and orthopedics emphasizing recent developments related to patient rehabilitation and a meeting with pediatrics dedicated to adolescent medicine. A seminar jointly sponsored with several other departments and marked by excellent attendance discussed newer concepts in the field of human sexuality.

Topic Selection

During the early phase of development, it became evident that the effectiveness of the seminar sessions could be enhanced if the participating physicians could have a direct input in planning the programs. To accomplish this a questionnaire is now sent to all participating doctors at the beginning of each year. The questionnaire provides all the family physicians with an opportunity to state their preference for topics to be covered and to indicate their feelings as to the relative importance of the suggested subjects in a numerical manner. The results of the 1976 survey are summarized in Table I.

The Relative Interest of Continuing Medical Education Topics Expressed by Responding Physicians

Topics Listed in Accordance to Rank

1. Cardiovascular diseases
2. Pulmonary diseases
3. Infectious diseases and antibiotics
4. Endocrinological problems including diabetes, thyroid diseases, etc.
5. GI diseases
6. Eye diseases
7. Surgical problems including acute abdomen and minor surgery
8. Oncology
9. Nutrition problems including treatment of obesity and hyperlipidemia
10. Skin diseases
11. Muscular sketetal disease and orthopedic problems
12. ENT problems
13. Urological problems
14. Neurological problems including treatment and diagnosis of headache
15. Gynecological problems
16. Interpretation of x-ray films
17. Geriatric problems

Comments

Although it is our opinion that none of the subjects included in the Table should be removed from a continuing medical education curriculum, every effort should be made to emphasize those subjects for which preference has been expressed by the participating physicians. This approach will satisfy the participating physicians' interest as well as lead to better attendance at the various meetings.

Conclusion

The increasingly important role of continuing medical education is clearly evident. One of the most logical settings for economical, quality,

*Programs approved for Category I or Prescribed Credit are accepted for Mandatory Credit under the Florida Medical Association's CME program for its members. In the absence of AMA or AAFP credit, application may be made to the FMA Committee on Continuing Medical Education for Mandatory Credit.

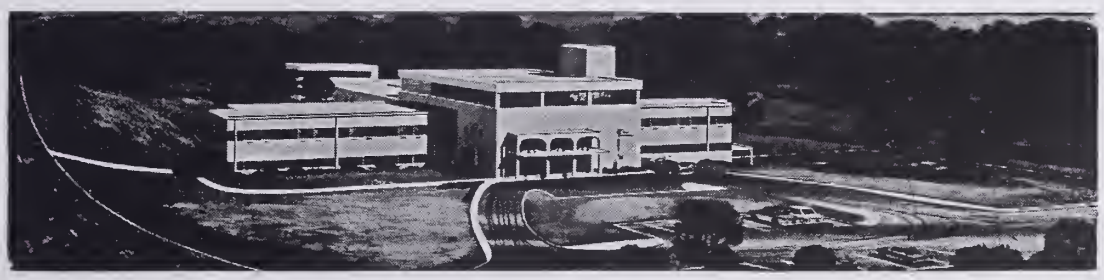
ongoing continuing medical education for physicians is through their local community hospital. This approach to providing meaningful education for family practitioners has been tried successfully and should lend to application in virtually every community hospital. Through experience it has been demonstrated that courses devised and structured as previously discussed, if implemented with care and attention given to detail, will be well attended and elicit the interest of the physicians. It is likely that this program presented in an interesting manner will be better or longer retained, and that reinforcement through repetition enhances learning. If properly structured and accredited, educational programs of the types discussed can provide physicians with an economical means of keeping up to date with new developments in diagnostic techniques and therapeutic remedies.

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Specialty Choices of Florida's 1977 Medical School Graduates

Kenneth E. Penrod, Ph.D.

> The availability of high quality health care to all Americans is a national goal . . . and is, to a substantial extent, dependent upon the availability of qualified health professions personnel and adequate numbers of physicians engaged in the delivery of primary care, including family practice, general internal medicine, and general pediatrics, and in the various specialties, but in numbers which do not exceed the need for physicians in such specialties.
>
> —PL 94-484, Health Professions Educational Assistance Act of 1976

Florida's Representative Paul Rogers and his colleagues who authored this Act recognized the disproportionate need for "physicians engaged in the delivery of primary care, including family practice, general internal medicine, and general pediatrics." As a stimulus to medical schools to attempt to influence more students to enter these specialties a proviso was attached to that portion of the Health Manpower Act that provides funds for medical school assistance, making such payments contingent upon meeting certain goals.

This requirement states that at least 35% of the filled first year residency positions on 15 July 1977 in a medical school's direct and affiliated graduate programs must be devoted to family practice, general internal medicine and general pediatrics. In 1978 the percentage is increased to 40 and in 1979 and subsequent years it is 50%.

In the light of these requirements, and since first year residents (PGY-1) are, for the most part, recent graduates of medical schools it is of interest to look at the specialty selections of Florida's 1977 graduates.

It is pleasant to note (Table 1) that more than half the graduates of each of our medical schools have opted for careers in primary care specialties of FP, IM and PD, well above the minimums spelled out in the Health Manpower Act. These data would seem to indicate that FLorida's recent graduates are indeed attuned to the times with regard to specialty selection. However, there may be reason to be less sanguine about the ultimate outcome of this apparent enrollment in primary care specialties.

A year or more of residency in internal medicine is often judged to be of great value before beginning some of the other specialties. In addition many who entered the IM graduate programs in the past have continued training into subspecialization fields not generally considered to be primary care. In some degree the same may be said about pediatric residencies.

The use of residency input data to predict ultimate practice patterns may be a critical weakness of the Health Manpower Act. This fact was known both to the Congress and to the Physician Manpower Branch of HEW which is charged with administration of the Act. In consequence, the final regulations pertaining to the Act's administration still have not appeared, but there is every indication that these numbers and percentages will be revised after passage of some period of time.

To gain a better perspective of residency input data vs ultimate practice careers the 1972 graduates of the Universities of Miami and Florida were examined. These data now show:

Total entering internal medicine residencies in 1972, 49

Now listed* as general internists, 17 (35%)

Now listed as medical specialists, 24

Now in other fields (nonprimary care), 6

Now inactive, 2

Total entering pediatrics residencies in 1972, 10

Now in primary care practice, 6

Now in specialized practice, 2

Now in other fields (nonprimary care), 2

If the 1977 graduates follow in the pattern of their 1972 predecessors, the actual number providing primary medical care five years hence will be appreciably less than the 54% now beginning residencies in the three specialties under discussion. If it is assumed all 25 of the FP residents will stay in FP and 35% of the 108 beginning IM (38)

Dr. Penrod is Staff Director of the Community Hospital Education Program.

*AMA files

Table 1.—Specialty Selections of the 1977 Graduates of Florida's Medical Schools

	UM	UF	USF	Totals
FP	8	10	7	25
IM	49	41	18	108
PD	8	10	10	28
Subtotal	65	61	35	161
OBG	9	11	5	25
PTH	2	4	3	9
P	8	2	3	13
R	3	5	4	12
GS	20	12	10	42
Flex. Int.	9	10	2	21
Other	7	7	2	16
Total Grads.	123	112	64	299

will practice general internal medicine, and 60% of the 28 beginning PD (17) will practice general pediatrics we are left with a total of 80 primary care physicians in those three specialties. This is 27% of the 299 total graduates rather than the 54% suggested by the residency input data.

In singling out FP, IM and PD the authors of the Health Manpower Act deny any attempt to define, or limit, the make-up of primary care. They refer to family practice, general internal medicine and general pediatrics as primary care fields, but not as the primary care fields. In the final analysis it is primary care physicians who are being sought, by whatever definition.

There is no consensus on what primary care is or which physicians are actually providing it. Most definitions include OBG in primary care although it was not included in the Health Manpower Act. Too, based on past experience there is reason to believe at least half of those who begin their graduate training as flexible interns will end up in primary care fields. If, among Florida's graduates of 1977, the 25 OBG residents and 10 of the flexible interns are added to the 80 computed above to be headed for primary care careers a total of 115 is obtained, 38% of the graduating classes.

Discussion

At the same time that a larger number of medical school graduates appear to be opting for careers in the primary care specialties of medicine a subtle, but powerful, factor may be influencing this decision. This is the availability of PGY-1 training opportunities.

In 1976 slightly over 50% of all first graduate year positions offered in the U.S. (of a total of 16,112) were in FP, IM and PD. In just two years the number of opportunities in these three specialties increased by 1,441 positions while the total number of openings decreased 1,291. Their percentage of all positions offered increased from 38.7 to 50.8.[1] The Coordinating Council on Medical Education, American Board of Medical Specialties, and other responsible bodies are making a serious effort to achieve the goal of "adequate numbers of physicians . . ., but in numbers which do not exceed the need for physicians in (each) specialty."

The selection of medical specialty careers by Florida's medical graduates is probably only slightly, if at all, affected by this availability factor to this time. Nevertheless, between the 1972 and 1977 classes the percentage of graduates beginning their PGY-1 training in FP, IM or PD increased from 40% to 54%.

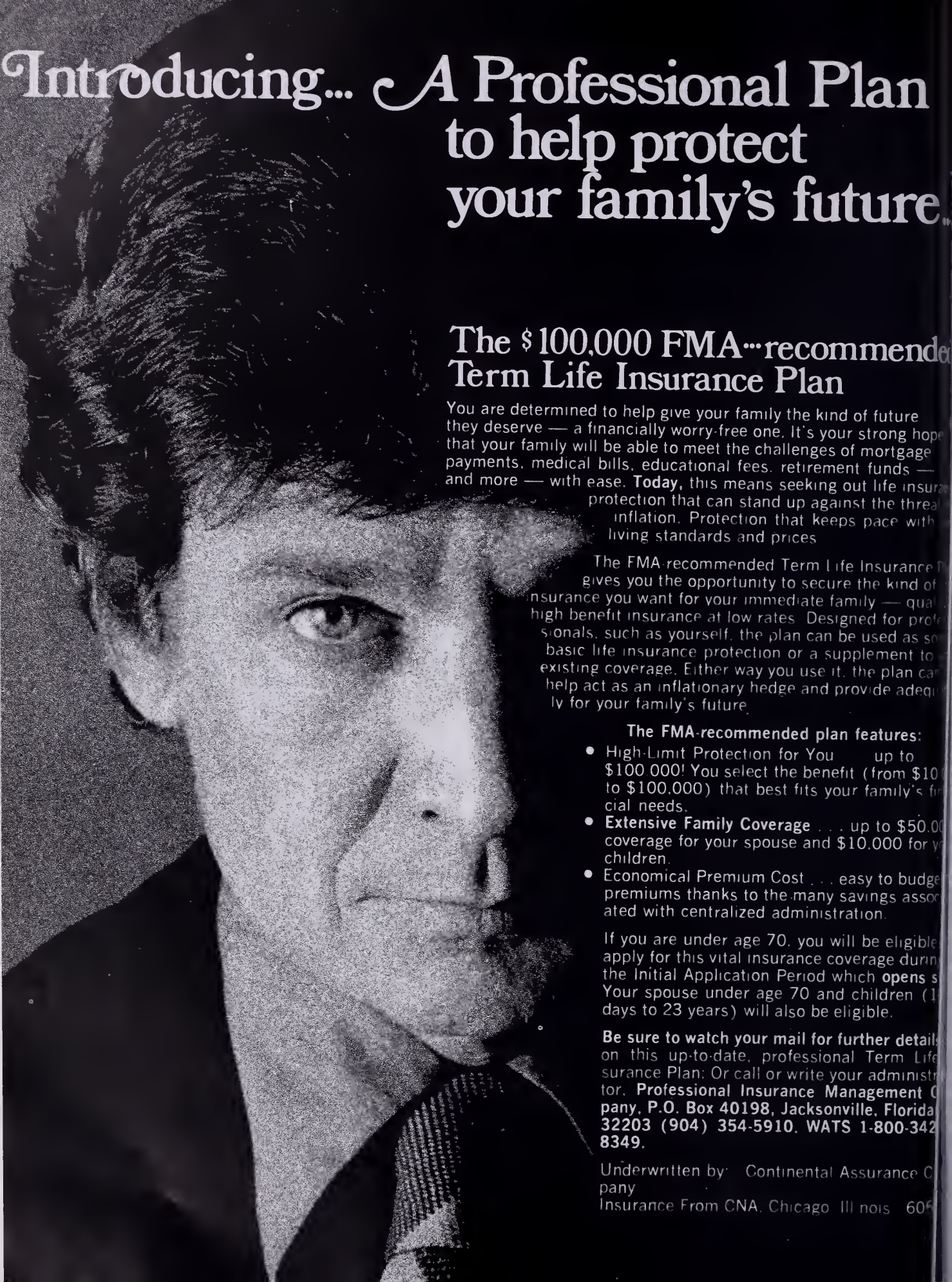
The trend of specialty selection seems clear.

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● Dr. Penrod, 107 West Gaines Street, Tallahassee 32304.

There may be said to be two classes of people in the world: Those who constantly divide the people of the world into two classes, and those who do not. — Robert Benchley



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EDITORIALS

Welcome, Students!

In recent months, the more ardent readers of The Journal may have noticed the addition of the names of three "misters" into the roster of our editors on the contents page.

These three "laymen" actually are medical students at our three medical schools who, in a very few years, will be joining the bulk of our readership in the practice of medicine.

In 1974, the FMA House of Delegates, acting upon a joint recommendation of the Judicial Council and the Council on Scientific Activities, and after the approval by the Board of Governors, amended the Association's By-Laws to permit for the first time medical students to become members of county medical societies and the FMA.

For the last two years, medical students have been serving as voting members of the FMA House of Delegates, but the appointment of Mr. Alan D. Zablocki, a student at the University of South Florida College of Medicine, as a member of the Comittee on Scientific Publications, marks the first time that a medical student has served as a voting member of an FMA Committee.

Two other students — Mr. Richard J. Snyder of the University of Miami School of Medicine and Mr. Jerrold A. Van Dyke of the University of Florida College of Medicine — have been appointed to The Journal's panel of consulting editors.

The Committee on Scientific Publications commends the FMA Board of Governors for enthusiastically embracing the concept of student input into The Journal's affairs.

Gratitude is due Dr. J. Donald Wargo and his Committee on Medical Education for suggesting the plan for appointing students to these positions. Under the rotational system originally suggested by Dr. Wargo's Committee, each medical school will have a student serving on the Committee and as a Journal Assistant Editor every third year. In the intervening two years, each school will have a student serving as a consulting editor.

Also to be commended are our medical school deans and their assistants who promptly surveyed their student bodies and suggested top quality students for appointment to these positions.

Your Journal should be all the richer for the addition of the student viewpoint into its editorial affairs. This represents a new dimension.

So, we give a hearty welcome to Messrs. Zablocki, Snyder and Van Dyke. We know each will learn much from their new associates; and we shall learn much from them.

The Editor

Idealism increases in direct proportion to one's distance from the problem. — John Galsworthy

A Prayer for the New Year

Instead of trying to resolve what kind of a person one will be in the new year, why not imagine what you will be like in 1988, not how you will look or how much money you have or what you will be doing but what kind of person you will be then. Examine yourself objectively and decide whether, if you keep on as you are now, you will turn out to be the kind of person you, yourself, would admire, trust and respect.

As each morning's sunrise awakens us to new ideas and ambitions, seldom do we think about such things, but how timely and profitable such a personal research could be. For what a person is going to be next year and the next and the year after that, he is becoming day by day. For if under one's affectations, there are solid elements of kindness, fairness, sincerity, unselfishness, humility, intellectual honesty and self respect, then can these be the foundation stones upon which to develop one's character and one's life—for no matter at what stage in life we now are, we can still make a start on what we would like to be at the end of each year.

As the greatest glory of a building is not in its stones but in its years of stern watching, of approval or condemnation, with its walls long washed by passing waves of humanity and its quiet contrast with the transitional character of all things; so is admired the self reliant individual, refusing to surrender to the oncoming years, whose steadfast courage to persevere, affirms that the impossible does not exist for the man whose self-confidence will not grow old while knowledge can keep it young.

Looking back on the old year's disillusions, disappointments and days of depression, it becomes apparent that so often such are only tests or yardsticks to take the true measure of a man. As the worthy man bears the trials and anguish of life with dignity and grace, making the best of circumstances, so, during the old year, did thousands of people accept the challenges that destiny flung at them to be met by two personal qualities—faith and courage. Failure need be but an episode in a man's life, not the whole story. It depends on the man.

Although no two of us on earth are born with the same talents, have equal stores of energy or similar desires, still no one man or woman of the humblest sort can be really strong, gentle, pure or good without the world being a better place, or without somebody being helped and comforted. So, whether or not we may be aware of it our presence and our behavior influences others.

As the kind of influence we have is determined by our thoughts, our secret desires, our intellectual honesty and our attitude toward others, so, in the new year, it becomes obvious that this is the most important contribution to the world that we can ever make.

While in years gone by, in the battle for justice and equality, too often have we allowed our dreams to be destroyed with apathy, our vision with sophisticated arrogance, and our prophecy with pragmatism; so in the new year, let us dream again and free ourselves to develop a versatile mind, an abiding faith and an appreciation of our cultural heritage so that we might be prophets of liberation, reconciliation and good will.

C.M.C.

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ORGANIZATION

FMA's New Headquarters Office Building and Regional Offices

W. Harold Parham, D.H.A.

The FMA Headquarters in Jacksonville moved to its new building at 801 Riverside Avenue in October of 1977. The purchase of this 12-year-old building and outstanding riverfront property was made possible by a variety of circumstances. Due to the recession, difficulties that the over-all insurance industry has experienced in recent years, and the consolidation of offices by Commercial Union Insurance Company (former owners of the building) the FMA was able to obtain this property at an excellent price.

The FMA building and property at 735 Riverside Avenue was sold December 1, 1977 for more than its current book value. It was built in 1956 with additions in 1960 and 1975.

FMA is housed on the second floor of the two-story Georgian red brick building with PIMCO leasing part of the first floor. Being housed under the same roof has enabled the two organizations to function more efficiently and to share many of the costs and equipment formerly incurred individually. There is ample space for future growth by both organizations.

In addition to moving to the new headquarters, FMA has opened two new regional offices—one in Miami to serve south Florida, and another in Tampa, to serve central Florida. These two offices are in addition to the Capital Office in Tallahassee, which has been in operation since 1969.

The purpose for the opening of these two additional offices is service to the news media, legislators, county medical societies, and physicians in the state. Florida's growing population and the increasing complexity of the medical activities, indicated a need for expanded service by the FMA.

The FMA South Florida Office opened officially November 1, 1977. It is housed in the Central Bank Building, 18350 N.W. 2nd Avenue, Miami, with Mr. Eugene H. Johnson as manager. A native of Minnesota and formerly associated with the Dade County Medical Association, Mr. Johnson will be responsible for implementing the programs and policies of the FMA, as well as assisting the county medical societies and physicians in the south Florida area.

The Central Florida Regional Office, located in the Tampa Host International Hotel at Tampa Airport, is managed by Mr. Russell E. Berge. Mr. Berge is a native of North Dakota and formerly served as Administrative Assistant to members of the Florida House and Senate.

The Capital Office in Tallahassee will serve as the North Florida Regional Office, thus placing FMA offices in all major areas of the state.

Mr. George S. Palmer, Jr. will continue as manager of the Capital Office in Tallahassee, and is responsible for field work in North Florida in addition to his duties of Executive Director of FLAMPAC.

The Legislative Affairs Department will continue to be housed in the Capital Office headed by Mr. Donald S. Fraser, Jr.

The purpose and function of these branch offices is to develop an indepth, integrated program for legislative education and activities; public relations, and political education. These offices and their staffs are intended to assist in coordination of the activities of county medical societies and not in any way to interfere with or replace current programs and activities.

Dr. Parham is Executive Vice President of the Florida Medical Association.

Florida Medical Association House of Delegates Called Meeting
February 4-5, 1978
Dutch Inn, Lake Buena Vista

Dr. Louis C. Murray, FMA President, has announced to all FMA Delegates that there will be a Called Meeting of the FMA House of Delegates, Saturday, February 4, through Sunday, February 5, 1978, at the Dutch Inn in Orlando, Florida.

The purpose of the Called Meeting is to consider the Association's state and national legislative programs and other business previously approved by the Board of Governors. The following format for the meeting has been approved and will include a President's report on the Association's priorities at the first House of Delegates.

First House of Delegates—Saturday, February 4 — 9:00 a.m.

Reference Committee (1) — Saturday, February 4 — 10:30 a.m.

General Session — Saturday, February 4 — 2:00 p.m.
(To include FMA Leadership Conference)

FLAMPAC Workshop — Saturday, February 4 — 3:30 p.m.

Second House of Delegates—Sunday, February 5 — 9:00 a.m.

In compliance with the FMA bylaws, the specific agenda will be sent to delegates at least 30 days prior to the meeting.

Reference Committee

There will be a Reference Committee appointed which will meet at 10:30 a.m., on Saturday, February 4, to consider Reference Committee reports.

Miscellaneous Meetings

Additional miscellaneous meetings held in conjunction with the Called Meeting of the House are not recommended and may only be held subject to the availability of space.

Second Annual Physician Recruitment Conference

Foreword

The Second Annual Physician Recruitment Conference highlights a subject needful of attention by every Florida physician. The "maldistribution" of doctors—the needs for physicians in rural communities and other medically underserved areas—has become a matter of public and political debate with far-reaching potential consequences. It was the focus of a Bill considered by the past Florida Legislature and is re-agendaed for more attention in 1978. Organized medicine must be involved in planning the mechanisms for assuring adequate medical coverage for all in need. — E. Charlton Prather, Associate Editor.

Florida has the sixth largest physician population in the nation with some 14,000 licensed M.D.'s now residing in the state. Yet, in some areas of Florida, according to the Department of Health and Rehabilitative Services and the State Board of Medical Examiners, there is a shortage of doctors.

Last year, 2,464 physicians obtained licenses to practice in Florida. Many of them were specialists who, by the nature of their specialty, were attracted to urban areas. Some were foreign medical school graduates who found greater acceptance in urban areas, and others found they could practice better if they were near a hospital.

The influx of physicians into the state has done little to solve the problems of medically underserved rural communities. Twenty-two of Florida's 67 counties have been designated as areas of urgent need for a variety of reasons as determined by state and federal agencies. One outstanding criterion for being categorized as medically underserved is the fact that the county does not have a physician/population ratio of one physician for every 3,500 residents. It is estimated that four counties have no physician at all.

The Florida Medical Association, in cooperation with the Florida Academy of Family Physicians, gained a foothold in rectifying this situation at the Second Annual Physician Recruitment Conference held October 29 in Gainesville.

The purpose of the conference was to bring together community representatives in search of physicians and physicians seeking practice opportunities. The audience of nearly 100 heard from leaders of successful physician recruitment programs in the states of Virginia and Arkansas, as well as from a practicing rural physician.

Edgar T. Fisher, Jr., Director of the Virginia Council on Health and Medical Care, stressed the need for communities to present an organized front when recruiting physicians. Communicating, cooperating and coordinating are the keys, according to Fisher, who listed 40 aspects of concern to doctors when considering location in which to establish a practice. Heading the list is the climate and geography of the community, followed by the availability of clinical support and the opportunity to join an existing practice. Also of prime importance is the quality of education available for children, proximity to a medical school, income, and access to continuing medical education.

Fisher explained that many communities make the mistake of not considering medical residents who, because of further training, will not be available to practice in the community for one to two years. "Certainly, you needed a doctor yesterday, but you have to think of tomorrow," he said. Other mistakes made by communities may seem minor, but are actually very important. Fisher said he has heard of incidents where community leaders expected the prospective doctor to pick up the tab for social functions arranged by his hosts. Excluding local physicians from the recruiting process is also a negative factor according to Fisher, as is expecting the new doctor to practice in cramped quarters, changing verbal agreements or not putting agreements in writing, underestimating the influence of the doctor's wife or getting discouraged.

If more physicians aren't recruited to serve in areas of critical need, there is a possibility that a type of socialized medicine will fill the void, warned William Huddleston, Director of the North Arkansas Human Services Center. The threat of big government stepping in should spur community leaders into re-thinking their approach to recruitment, he advised.

According to Huddleston, the Arkansas program combines the best aspects of both profit and non-profit models backed by an initial government grant to provide health care to rural areas. The project, which began with a part-time psychologist and a budget of $20,000, has since grown to a staff of 80 and a $1.7 million annual budget.

The government sponsored National Health Service Corps (NHSC) was outlined by Steve King, M.D., Associate Director of the Division of Health Services, DHEW in Atlanta. By subsidizing the education of medical school students, NHSC can call on newly graduated doctors to serve in areas of critical need as "repayment." The program is working, Dr. King explained, because the health of Americans is considered an important resource.

The growing system is dependent on sophisticated support which is not generally available in rural areas, explained Wilmer J. Coggins, M.D., a member of the FMA Committee on Rural Health and a Professor in the Department of Community Health and Family Medicine at the University of Florida. This burgeoning system suffers problems which are more prevalent in rural areas due to a disproportionate allocation of funds. Another contributing factor to the rural physician shortage, according to Dr. Coggins, is the denial of politicians of the need for health care facilities.

Practicing in a rural community can be a rewarding experience, according to Herbert E. Brooks, M.D., Vice Chairman of the FMA Rural Health Committee and a practicing family physician in Bonifay, a rural community of 3,000. "You have more control over your life; the people are friendly and loyal and the recreational bonuses are superb." Mrs. Brooks, who has gained a doctorate in education since living in this Panhandle community asserts, "there are only self-imposed restrictions to rural living." She feels the key to a doctor's success in rural practice depends to a large degree on whether his wife accepts and enjoys the lifestyle.

Other speakers at the conference included J. Lee Dockery, M.D., of Gainesville, Vice President of the FMA; and Dick L. Van Eldik, M.D., of Lake Worth, President of the Florida Academy of Family Physicians.

Duke Medical Center Honors FMA Secretary Windom



Dr. Windom

Robert E. Windom, M.D., Secretary of the Florida Medical Association, Inc., for the last two years, has received a Distinguished Alumni Award from Duke University Medical Center.

Dr. Windom, a Sarasota internist, was honored for his professional accomplishments and community service during ceremonies at Durham, N.C., in November. A native of Columbus, Ohio, Dr. Windom received his M.D. degree at Duke in 1956.

Professionally, Dr. Windom has been active for many years in the American Heart Association, Florida Affiliate, which he served as President one year. He is Chief of Staff of Sarasota Memorial Hospital and serves as Clinical Associate Professor of Medicine at the University of South Florida College of Medicine and the University of Miami School of Medicine.

Prior to his election as Secretary of FMA in 1976, he served as Chairman of the FMA Council on Voluntary Health Agencies and Chairman of the Committee on Press, Radio and Television.

In his community, Dr. Windom has been President of the Sarasota County Chamber of Commerce, a trustee of New College and a member of the Board of Directors of the Sarasota Chapter of the American Red Cross. In 1973, he received the Outstanding Citizen of Sarasota Award.

Dr. Luis M. Perez of Sanford Gets AMA's Rush Award

Luis Martin Perez, M.D., of Sanford, a Cuban immigrant known for his staunch opposition to communism and defense of democracy, has received the American Medical Association's fifth Dr. Benjamin Rush Bicentennial Award for Citizenship and Community Service.

He formally received the award during the interim meeting of the AMA House of Delegates on December 4 in Chicago. The $5,000 cash award is made possible by a bequest in the will of the late Thomas G. Sheen of Atlantic City, N.J., in honor of his brother, Rodman E. Sheen, M.D.

The first Rush Award was presented in 1973 to Otis R. Bowen, M.D., Governor of Indiana.

A busy cardiologist and internist, Dr. Perez has nevertheless found time to wage his own fight against communism; to impress upon Americans their duties as citizens of a democracy; to achieve a better life for the underprivileged; to combat drug abuse; and to bridge the "generation gap." He is a gifted public speaker, an asset that has enhanced his effectiveness in these and other areas.

But the ardor of Luis Perez is expressed as often in actions as it is in words.

Items:

One year he took a booth at the Seminole County Fair from which he dispensed American flags, copies of the Declaration of Independence, the Pledge of Allegiance and the Bill of Rights.

When the U.S. Supreme Court banned mandatory prayer in the public schools, Dr. Perez persuaded the Seminole County School Board to initiate classroom readings from the Constitution of the United States and Declaration of Independence.

In 1968 he took a week off to tour the Seminole County school system, showing films he had rented on drug abuse to parents and students.

Dr. Perez organized a committee that formed a chapter of Boy's Club of America in Seminole County.

He rented an auditorium in Sanford and staged a semi-monthly series of "Generation Gap" meetings that brought adults and youths together in dialogue on a wide variety of topics. These meetings gave birth to a joint adult-youth project known as The Village or Half-Way House, an information and assistance center for persons beset by drug and other problems.

In 1971, the Florida Medical Association recognized Dr. Perez's accomplishments and devotion to his fellow man by naming him the recipient of the A. H. Robins Company Award for Outstanding Community Service by a Physician.

Dr. Perez was born in Camaguey, Cuba, and received his M.D. degree from the University of Havana Medical School in 1955. He came to the United States soon after graduation and did an internship and a residency in internal medicine at Georgia Baptist Hospital in Atlanta.

He is married to Maria P. Perez, a dermatologist. They have two sons.





Luis M. Perez, M.D., of Sanford (left in left picture) receives the 1977 Benjamin Rush Award from John H. Budd, M.D., President of the American Medical Association. In right picture, Drs. Perez and Budd view the award along with Dr. Perez's wife, Maria P. Perez, M.D. (Photos Courtesy of American Medical Association)

Three Medical Students Named To Journal Posts



Mr. Richard J. Snyder



Mr. Jerrold A. Van Dyke



Mr. Alan D. Zablocki

The appointment of three medical student members of FMA to editorial positions on **The Journal of the Florida Medical Association** has been announced by Editor Gerold L. Schiebler.

Mr. Alan D. Zablocki, a graduating student at the University of South Florida College of Medicine, has been named an Assistant Editor of **The Journal** and a member of the FMA Committee on Scientific Publications.

He becomes the first student to serve on an FMA committee or council since the Association began admitting medical students in 1974.

Named Consulting Editors of **The Journal** were Mr. Richard J. Snyder, a third-year student at the University of Miami School of Medicine; and Mr. Jerrold A. Van Dyke, a student at the University of Florida College of Medicine.

Under a plan suggested by the FMA Committee on Medical Education, Mr. Snyder will succeed Mr. Zablocki as Assistant Editor and member of the Committee on Scientific Publications when the latter graduates. A new student Consulting Editor would then be appointed from the University of Miami, and he or she will serve in that position for two years prior to one year as Assistant Editor.

All three students were recommended for appointment by their deans.

Mr. Zablocki, 25, was born in St. Petersburg, where he attended St. Petersburg Junior College for two years. He graduated cum laude from the University of South Florida with a B.A. degree in zoology in 1975. As a medical student, he is a member of Alpha Omega Alpha.

At the present time he is undecided between careers in internal medicine and in surgery, but he plans to return to Florida to practice following completion of his graduate training.

Mr. Snyder is a 24-year-old native of Miami Beach. He attended the University of Florida, where he received a B.S. degree in chemistry with honors in 1975. During his final year at Florida, he was President of the local chapter of Alpha Epsilon Pi Social Fraternity, which was chosen the most outstanding chapter of that organization in the nation.

Now in his third year at the University of Miami Medical School, he has served for the last two years as co-editor of the School's newspaper, **The Apprentice.**

During his first two years at the University of Miami, Mr. Snyder was first a member, then the Director for the school's Venereal Disease Lecture Program, which arranged lectures for area junior and senior high schools.

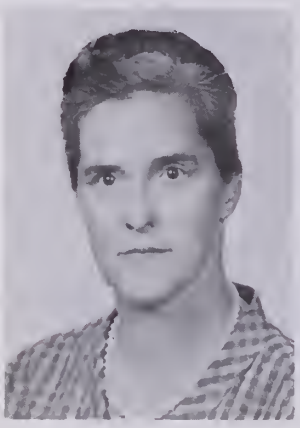
Mr. Van Dyke, also 24, was born in Denver, Colo. He was valedictorian of his high school graduating class in Miami, then attended Calvin College in Grand Rapids, Mich., for two years.

He graduated from the University of Florida with a B.S. degree awarded with high honors in 1975. His grades earned him a Phi Beta Kappa key.

Mr. Van Dyke entered the College of Medicine at the University of Florida in 1975.

Pinellas Physician Is New President Of American Medical Women's Association

Charlotte Herman Kerr, M.D., of Seminole, has been installed as President of the American Medical Women's Association.



Dr. Kerr

The inauguration took place on December 3 at the Association's 62nd Annual Meeting in Denver, Colo. Active in the organization for many years, Dr. Kerr previously held office as President of the Branch #2 in Chicago, national Treasurer, Second and First Vice President and President-Elect.

The new AMWA President is a native of Champaign, Ill., She attended the University of Illinois, receiving a Bachelor of Science degree in 1940 and her Doctor of Medicine degree in 1948. She served an internship and a residency in obstetrics and gynecology, both at Cook County Hospital in Chicago.

Dr. Kerr also holds an M.S. degree in nutrition from Iowa State University.

Prior to moving to Florida in 1974, Dr. Kerr practiced for 20 years in Chicago and in Michigan City, Ind.

Her other professional memberships include the American College of Surgeons, the American College of Obstetricians and Gynecologists, the Pinellas County Medical Society, the Florida Medical Association, and the American Medical Association.

Dr. Kerr is married to John E. Kerr, M.D., a urologist. They have a daughter, Patricia, 22.

Ft. Walton Beach Radiologist Heads SMA

Andrew F. Giesen, M.D., Ft. Walton Beach radiologist, has assumed the presidency of the Southern Medical Association. The installation took place at the President's Luncheon on November 8 during SMA's 71st Annual Scientific Assembly in Dallas, Texas.

A native of Virginia, Dr. Giesen received his M.D. degree from Tulane and completed internship and residency training at Philadelphia General Hospital in Philadelphia. He has been very active in SMA's Radiology Section, holding the offices of Secretary, Vice-Chairman, Chairman-Elect, and Chairman.

Dr. Giesen's other professional memberships include the Okaloosa County Medical Society, the Florida Medical Association and the American Medical Association. He is a Fellow of the American College of Radiology and a Diplomate of the American Board of Radiology.

Journal Announces County Medical Society Bulletin Awards Contest

The **First** Annual **Journal of the Florida Medical Association** Awards Contest for County Medical Society Bulletins has been announced by JFMA Editor Gerold L. Schiebler.

Awards will be given in five categories: General Excellence; Most Improved Bulletin; Best Editorial; Best Regular Feature; and a Special Recognition category for some commendable aspect of a publication that does not come within the other award classifications.

The contest period covers all issues published during calendar year 1977. Deadline for entries is February 1, 1978.

The Dade, Broward, Palm Beach, Hillsborough, Pinellas, Polk, Escambia and Duval County medical societies publish county society bulletins.

Awards will be presented during the second session of the House of Delegates at the FMA Annual Meeting at the Diplomat Hotel in Hollywood on Saturday, May 6, 1978.

Dr. Hallock New Associate Dean At South Florida



Dr. Hallock

James A. Hallock, M.D., of Tampa . . . has been appointed Associate Dean of the College of Medicine and Assistant Director of the Medical Center at the University of South Florida.

The appointment, effective last November 1, was announced by Hollis G. Boren, M.D., Dean of the College and Director of the Center.

A native of Paterson, N. J., Dr. Hallock received his M.D. degree at Georgetown University in 1967. He received internship and residency training in pediatrics at Children's Hospital and the Hospital of the University of Pennsylvania, both in Philadelphia.

He joined the University of South Florida faculty in 1972 and was promoted to Associate Professor of Pediatrics in 1975. He is a Diplomate of the American Board of Pediatrics, and in 1976 he was cited as the outstanding clinical professor at the USF College of Medicine.

His professional memberships include the American Academy of Pediatrics, the Hillsborough County Medical Association and the Florida Medical Association.

In his new post, Dr. Hallock will work closely with Dr. Boren and will serve as Chairman of the Curriculum Committee. He also will continue patient care and teaching duties with the Department of Pediatrics.

Preliminary Program
104th Annual Meeting Scientific Program

More than 30 of the Florida Medical Association-recognized specialty groups plan to participate in the 104th Annual FMA Meeting's scientific program next year.

The convention will be held Wednesday through Sunday, May 3-7, with scientific meetings scheduled for all but Sunday. The convention site is the Diplomat Hotel in Hollywood.

Application will be made to the Medical Education Committee of the Florida Medical Foundation for 20 hours of AMA Category 1 Credit, according to Henry M. Yonge, M.D., of Pensacola, General Program Chairman. He said American Academy of Family Physicians Prescribed Credit will be sought for certain elements of the program.

Dr. Yonge said two popular educational activities sponsored by drug companies will be back for the third year. Pfizer Laboratories will present four hours of "Dialogue", and Wyeth Laboratories will return with programmed instruction using Auto-Tutors.

The following scientific section programs had been submitted when **The Journal** went to press. Other programs will be published as they develop in future issues:

WEDNESDAY AFTERNOON — MAY 3

SECTION ON INTERNAL MEDICINE
(Co-sponsored by American College of Physicians and Florida Society of Internal Medicine)
Wednesday—1:00 p.m. to 4:15 p.m.
George J. Caranasos, M.D., Gainesville
Program Chairman

"Gastrointestinal Absorption and Obesity," James J. Cerda, M.D., Professor of Medicine, University of Florida College of Medicine, Gainesville.
Questions and Answers
"Surgical Approach to Obesity: Present Status," J. Patrick O'Leary, M.D., Associate Professor of Surgery, University of Florida College of Medicine, Gainesville.
Questions and Answers
"Nutrition for the Now Generation," Howard Appledorf, Ph.D., Associate Professor of Human Nutrition, University of Florida, Gainesville.
Questions and Answers
Adjournment

THURSDAY AFTERNOON — MAY 4

SECTION ON RHEUMATOLOGY
(Co-sponsored by Florida Society of Rheumatology)
Thursday—1:30 p.m. to 4:30 p.m.
Bernard F. Germain, M.D., Tampa
Program Chairman

"Infectious Arthritis," Frank Schmid, M.D., Professor of Medicine and Chief, Section of Arthritis/Connective Tissue Diseases, Northwestern Medical School, and Director, Arthritis Clinical Center, Northwestern University Medical Center, Chicago, Ill.
"Psoriatic Arthritis," Frank B. Vasey, M.D., Assistant Professor of Medicine, Section of Rheumatology, University of South Florida College of Medicine, Tampa.
"Radiologic Manifestations of Rheumatic Diseases," Roy Altman, M.D., Associate Professor of Medicine, University of Miami School of Medicine, Miami.

Case Presentations and Discussions
Adjournment

SECTION ON CHEST MEDICINE
(Co-sponsored by Florida Chapter, American College of Chest Physicians and Florida Thoracic Society)
Thursday—2:00 p.m. to 5:00 p.m.
A. Jay Block, M.D., Gainesville
Marcos Barrocas, M.D., Miami
Program Co-Chairmen

"Selected Topics in Noncardiogenic Pulmonary Edema"
Moderator: Roy Behnke, M.D., Chairman, Department of Medicine, University of South Florida College of Medicine, Tampa.
"Overview and Definition," Roy Behnke, M.D., Chairman, Department of Medicine, University of South Florida College of Medicine, Tampa.
"Near Drowning," Jerome Modell, M.D., Chairman, Department of Anesthesiology, University of Florida College of Medicine, Gainesville.
"Aspiration Pneumonia," James W. Wynne, M.D., Assistant Professor of Medicine and Anesthesiology, University of Florida College of Medicine, Gainesville.
"Traumatic Pulmonary Edema," Richard Virgilio, M.D., Chief, Shock Trauma Unit, Naval Regional Medical Center, San Diego, Calif.
Adjournment

FRIDAY MORNING — MAY 5

SECTION ON ORTHOPEDIC SURGERY
(SECTION I)
(Co-sponsored by Florida Orthopedic Society)
Friday—8:00 a.m. to 10:45 a.m.
Joseph C. Flynn, M.D., Orlando
Program Chairman

Welcome—Ronald J. Mann, M.D., President, Florida Orthopedic Society, Miami.
"Correlation of Clinical Impressions and Arthroscopic Findings of 500 Consecutive Knee Examinations," Carl L. Croft, M.D., Winter Park.
"Arthroscopy—An Update on 600 Cases," John P. Barrett, Jr., M.D., Clearwater.
"Patellar/Femoral Complications in Total Knee Arthroplasty," Jerry E. Enis, M.D., Miami.
"Total Knee Joint Replacements Utilizing the Marmor Modular Components," William H. Keeler, III, M.D., St. Petersburg.
"Noiles Total Knee Replacement," Leo M. Flynn, M.D., Pensacola.
Coffee Break
"Iatrogenic Systemic Lupus Erythematosus," Michael S. Zeide, M.D., West Palm Beach.
Adjournment

SECTION ON NUCLEAR MEDICINE
AND FAMILY PRACTICE
(Co-sponsored by Florida Association of Nuclear Physicians and Florida Academy of Family Physicians)
Friday—8:00 a.m. to 10:45 a.m.
Aldo N. Serafini, M.D., Miami Beach
E. F. Ciliberto, M.D., Tampa
Program Co-Chairmen

Introduction—E. F. Ciliberto, M.D., Chief of Undergraduate Education Section, Department of Family Medicine, University of South Florida College of Medicine, Tampa.
"Toxicology Update—Role of Radioimmunoassay and Other In Vitro Techniques," Laudie E. McHenry, M.D., Department of Pathology, Brevard Hospital, Melbourne.
"Thyroid Nodular Disease—Benign or Malignant," Fuad S. Ashkar, M.D., Associate Professor of Radiology and Medicine, and Director of the Radioassay Laboratory, Jackson Memorial Hospital and University of Miami School of Medicine, Miami.
"Hodgkin's and non-Hodgkin's Lymphomas," Michael B. Troner, M.D., Assistant Professor of Medical Oncology and Chief of the Medical Oncology Service, VA Hospital, Miami.
"Hepatobiliary Scanning in Acute Cholecystitis," Edward A. Eikman, M.D., Assistant Professor of Medicine, University of South Florida College of Medicine, and Chief of Nuclear Medicine, VA Hospital, Tampa.
"Myocardial Imaging in the Detection of Ischemic Heart Disease and Myocardial Infarction," Aldo N. Serafini, M.D., Assistant Professor of Radiology and Co-director of Ultrasound Section, Division of Nuclear Medicine, University of Miami School of Medicine, Mt. Sinai Medical Center, Miami Beach.
"The Role of Short Lived Radio Gasses in Cardio-Pulmonary Disorders," A. J. Gilson, M.D., Professor and Director of the Division of Nuclear Medicine and Ultrasoundography, University of Miami School of Medicine, Mt. Sinai Medical Center, Miami Beach.
"Complementary Role of Echocardiography and Nuclear Imaging in Cardiology," S. Gottlieb, M.D., Division of Nuclear Medicine, Department of Radiology, Jackson Memorial Hospital, Miami.
"Pediatric Nuclear Medicine," Dorothy T. G. Lloyd, M.D., Director of Nuclear Medicine, Orange Memorial Hospital, Orlando Regional Medical Center, Orlando.
Closing Remarks—Dr. Lloyd
Adjournment

SECTION ON OTOLARYNGOLOGY
(Co-sponsored by Florida Society of Otolaryngology)
Friday, May 5—8:00 a.m. to 10:45 a.m.
W. Mark Flintoff, M.D., Pompano Beach
W. W. McClerkin, M.D., Pompano Beach
Program Co-Chairmen

Allergy Quiz and Questionnaire
The Fitting and Dispensing of Hearing Aids: Point-Counterpoint (Discussion)
Clinical Pathological Conference
Discussant:
J. R. Chandler, M.D., Professor and Chairman, Department of Otolaryngology, University of Miami School of Medicine, Miami
Panelists:
Thomas C. Tyler, M.D., Venice
James F. Holly, M.D., Orlando
Robert K. Middlekauff, M.D., Jacksonville
"The Ear Surgeon of Tomorrow," J. Brown Farrior, M.D., Clinical Professor of Surgery, University of South Florida College of Medicine, Tampa.
Adjournment

SECTION ON PEDIATRICS
(Co-sponsored by Florida Chapter, American Academy of Pediatrics, and Florida Pediatric Society)
Friday—9:00 a.m. to 10:30 a.m.
James A. Hallock, M.D., Tampa
Program Chairman

"All You Wanted To Know About Perinatology But Were Afraid To Ask," Richard Boothby, M.D., Director, Florida Perinatal Association, Jacksonville.
Adjournment

FRIDAY AFTERNOON — MAY 5

SECTION ON COLON AND RECTAL SURGERY
(Co-sponsored by Florida Society of Colon and Rectal Surgeons)
Friday—1:30 p.m. to 4:30 p.m.
Walter W. Hamilton, M.D., St. Petersburg
Program Chairman

"Polyposis Syndromes in Relationship to Colon Cancer," J. Byron Gathright, Jr., M.D., Associate Clinical Professor of Surgery, Tulane College of Medicine, and Attending Staff, Department of Colon and Rectal Surgery, Ochsner Clinic, New Orleans, La.

"New Techniques in Diagnostic Radiology," Fred P. Gargano, M.D., Radiologist, Palmetto General Hospital, Hialeah.
"Local Transanal Excision of Adenocarcinoma of the Rectum," Jeff Harris, M.D., Colon and Rectal Surgeon, Tampa.
"Postoperative Ano-Rectal Bleeding," Emmet Ferguson, M.D., Colon and Rectal Surgeon, Jacksonville.

"Advances in Colonoscopy," John P. Christie, M.D., General Surgeon, Miami.
"Polyps of the Colo-Rectum: Current Status" (Panel)
Moderator: Walter W. Hamilton, M.D., Chief of Surgery, Palms of Pasadena Hospital, St. Petersburg.
Panelists: J. Byron Gathright, Jr., M.D., New Orleans, La.
Emmet Ferguson, M.D., Jacksonville
John Christie, M.D., Miami
Edward Willey, M.D., Pathologist, Palms of Pasadena Hospitals, St. Petersburg.
Questions and Answers
Adjournment

SECTION ON NEUROLOGY

(Co-sponsored by Florida Society of Neurology)
Friday—1:00 p.m. to 5:00 p.m.
Allan Herskowitz, M.D., North Miami Beach
Program Chairman

"Current Advances in Neuroimmunology," Robert Schwartzman, M.D., Associate Professor of Neurology, University of Miami School of Medicine, Miami.
"Neuro-Oncology," Martin Liebling, M.D., Clinical Associate Professor of Medicine, University of Miami School of Medicine, Miami.

"Current Concepts in the Treatment of Pain," Donald Dooley, M.D., Neurosurgeon and Medical Director, Pain Rehabilitation Center, Baptist Hospital, and Bernard Swerdlow, M.D., Psychiatrist and Attending Physician, Baptist Hospital, Miami.
Adjournment

SECTION ON THORACIC AND CARDIOVASCULAR SURGERY

(Co-sponsored by Florida Society of Thoracic Surgeons)
Friday, May 5—1:30 p.m. to 4:00 p.m.
Robert B. Trumbo, M.D., Orlando
Program Chairman

"Indications for Coronary Artery Surgery," Harold C. Urschel, M.D., President-Elect, Southern Thoracic Surgical Association, and Clinical Professor of Surgery, University of Texas Southwestern Medical School, Dallas, Texas.
"Treatment of Hiatal Hernia and Reflux Esophagitis," Dr. Urschel.

Panel on Esophageal Disease
Adjournment

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society for Preventive Medicine)
Friday—1:30 p.m. to 5:00 p.m.
James T. Howell, M.D., Palm Springs
Program Chairman

"Review of the Status of Maternal and Infant Care, State of Florida," Emily Gates, M.D., Family Health Program Medical Supervisor, and Staff, Health Program Office, Tallahassee.

"The Cooperative Approach to Rural Maternity Care: University and County Health Departments," Charles S. Mahan, M.D., Project Director, NCF MIC-FP-WIC Projects, Gainesville.
"The Role of Nurse-Midwifery in Modern Maternal and Infant Care," Anne Scrupholme, C.N.M., Department of Obstetrics and Gynecology, University of Miami School of Medicine, Miami.

REACTOR PANEL
June M. Murray, M.D., Director, Lake County Health Department, Tavares.
Samuel D. Rowley, M.D., M.P.H., Director, Duval County Health Department, Jacksonville.
Jorge Deju, M.D., M.P.H., Medical Administrator, Personal Health Program, Health Program Office, Tallahassee.

"Infectious Disease Update, State of Florida—To Include Dengue and St. Louis Encephalitis," R. Michael Yeller, M.D., Administrator, Disease Control, Department of Health and Rehabilitative Services, Tallahassee.
Adjournment

SECTION ON ORTHOPEDIC SURGERY (SECTION II)

(Co-sponsored by Florida Orthopedic Society)
Friday—1:30 p.m. to 5:30 p.m.
Joseph C. Flynn, M.D., Orlando
Program Chairman

"Flexible Implant Arthroplasty of the Wrist—Technique and Results," Alfred B. Swanson, M.D., Grand Rapids, Mich.
"Spinal Stenosis," Mark D. Brown, M.D., Miami.
"Recent Developments in the Diagnosis and Treatment of Low Back Problems," Charles A. Mead, Jr., M.D., Jacksonville.
"Salvage Procedure for Failed Lumbar Disc Surgery," Richard G. Dedo, M.D., Jacksonville.
"Use of Harrington Instrumentation in Unstable Axial Skeletal Fractures," Max F. Riddick, M.D., Winter Park.
"Treatment of Advanced Spondylolisthesis," Harry L. Shufflebarger, M.D., Coral Gables.
"The TLSO for Kyphosis," Barry J. Silverman, M.D., North Miami Beach.
"Use of Silastic Membrane in Recurrent Turret Exostoses: A Case Report," Roger L. Bourguignon, M.D., Orlando.
Adjournment

SECTION ON PSYCHIATRY

(Co-sponsored by Florida Council of District Branches of the American Psychiatric Association)
Friday—1:30 p.m. to 5:00 p.m.
Lionel H. Blackman, M.D., West Palm Beach
Program Chairman

"Understanding Psychosomatic Symptoms," Stanley Conrad, M.D., West Palm Beach.
"Psychosomatic Disorders in the Hospitalized Geriatric Patient," Norman Silversmith, M.D., West Palm Beach
"Psychosomatic Medicine: Unity of Body and Mind," Irving J. Crain, M.D., Clinical Assistant Professor of Psychiatry, New York Medical College, New York, N. Y.
"Psychosomatic Aspects of Alcoholism," Jose Almeida, M.D., Medical Director, Palm Beach Institute, West Palm Beach.
Adjournment

SECTION ON RADIOLOGY (SECTION I)

(Co-sponsored by Florida Radiological Society)
Friday—2:00 p.m. to 4:30 p.m.
Robert E. Williams, M.D., Lakeland
Program Chairman

Opening Remarks—Alfred Schick, M.D., President, Florida Radiological Society, and Chief Radiologist, Morton Plant Hospital, Clearwater.
"Skeletal Injuries in Sports," Lee F. Rogers, M.D., Professor and Chairman, Department of Radiology, Northwestern University Medical School, Chicago, Ill.
"C.A.T. vs. T.A.T. in the Spine," Fredie P. Gargano, M.D., Clinical Professor of Radiology, University of Miami School of Medicine, and Chief Attending Radiologist, Palmetto General Hospital, Miami.
"Gallium Imaging in Pediatrics," Richard E. Litt, M.D., Clinical Associate Professor of Radiology and Pediatrics, University of Miami School of Medicine, and Attending Radiologist, Variety Children's Hospital, Miami.
Adjournment

SECTION ON PATHOLOGY
(Co-sponsored by Florida Society of Pathologists)
Friday—4:00 p.m. to 5:00 p.m.
Morton J. Robinson, M.D., Miami Beach
Program Chairman

"A Cross Match, Is It Necessary?" Herbert F. Polesky, M.D., Director, Minneapolis War Memorial Blood Bank and Professor of Laboratory Medicine and Pathology, University of Minnesota School of Medicine, Minneapolis.
Adjournment

SATURDAY MORNING — MAY 6

SECTION ON ALLERGY AND IMMUNOLOGY
(Co-sponsored by Florida Allergy Society)
Saturday—8:00 a.m. to 12:00 noon
Samuel C. Bukantz, M.D., Tampa
Program Chairman

"New Concepts in Etiology and Treatment of Asthma," Richard F. Lockey, M.D., Associate Professor of Medicine, University of South Florida College of Medicine, Tampa.
"Clinical Evaluation of Immune Disorders," Morton L. Hammond, M.D., Clinical Professor of Medicine, University of Miami School of Medicine, Miami.
"Occupational Asthma," John E. Salvaggio, M.D., Henderson Professor of Medicine and Director of Clinical Immunology Section, Tulane Medical Center, New Orleans, La.
"Clinical Uses of Transfer Factor," Hugh H. Fudenberg, M.D., Professor of Medicine, and Chairman, Department of Basic and Clinical Immunology, Medical University of South Carolina, Charleston, S. C.
Adjournment

SECTION ON RADIOLOGY
(SECTION II)
(Co-sponsored by Florida Radiological Society)
Saturday—8:00 a.m. to 11:00 a.m.
Robert E. Williams, M.D., Lakeland
Program Chairman

"Angiographic "Evaluation of Upper G.I. Disease," Martin Silbiger, M.D., Associate Professor of Radiology, University of South Florida College of Medicine, and Co-Director, Department of Radiology, Tampa General Hospital, Tampa.
"Some Legal Problems in the Practice of Radiology," David Kirsh, M.D., Clinical Professor of Radiology, University of Miami School of Medicine, Miami.
"Trauma Quiz," Lee F. Rogers, M.D., Professor and Chairman, Department of Radiology, Northwestern University Medical School, Chicago, Ill.
Adjournment

SECTION ON ORTHOPEDIC SURGERY
(SECTION III)
(Co-sponsored by Florida Orthopedic Society)
Saturday—8:00 a.m. to 11:35 a.m.
Joseph C. Flynn, M.D., Orlando
Program Chairman

"New Principles in Managing Lower Limb Rotational Deformities in Children," Allen S. Watson, Jr., M.D., Fort Lauderdale.
"Case Report of Ewing's Sarcoma of Fibula—A 2½ Year Survival," Wallace E. Miller, M.D., Miami.
"Orthopedic Education: Demands and Trends," Merlin G. Anderson, M.D., Tampa.
"Transacromial Approach to Rotator Cuff Tears of the Shoulder" (Movie without Sound)—Lester A. Russin, M.D., Miami Beach.
"Fourth and Fifth Metacarpal Dislocations with Associated Hamate Fractures," W. Lee Moffatt, M.D., and William E. Burkhalter, M.D., Miami.
"Flexible Implant Arthroplasty in the Toes and Elbow: Technique and Results," Alfred B. Swanson, M.D., Grand Rapids, Mich.
"A Quantitative, Comparative Analysis of Fracture Healing Under the Influence of Compression Plating Versus Closed Weight Bearing Treatment," Donald Mullis, M.D., Augusto Sarmiento, M.D., and Loren Latta, P.E., Miami.
Adjournment

SECTION ON NEONATAL-PERINATOLOGY AND PEDIATRIC CARDIOLOGY
(Co-sponsored by Florida Society of Neonatal-Perinatologists and Florida Association of Pediatric Cardiologists)
Saturday—8:30 a.m. to 10:45 a.m.
Richard L. Bucciarelli, M.D., Gainesville
David G. Ruschhaupt, M.D., Jacksonville
Program Co-Chairmen

"Management of the Infant with Patent Ductus Arteriosus," Lt. Col. Robert DeLemos, M.D., Department of Pediatrics, United States Air Force Medical Center, Lackland Air Force Base, Texas.
Questions and Answers
"Age Dependent Response of the Patent Ductus Arteriosus to Indomethacin," Jean McCarthy, M.D., Neonatologist, All Children's Hospital, St. Petersburg.
"Respiratory Management of the Infant with Congenital Heart Disease," Eduardo Bancalari, M.D., Assistant Professor of Pediatrics, University of Miami School of Medicine, and Director, Regional Neonatal Intensive Care Center, Jackson Memorial Hospital, Miami.
"Myocardial Dysfunction Syndrome in Asphyxiated Newborns," Richard L. Bucciarelli, M.D., Assistant Professor of Pediatrics, Divisions of Neonatology and Cardiology, University of Florida College of Medicine, Gainesville.
Adjournment

SECTION ON CLINICAL ONCOLOGY
(Co-sponsored by Florida Society of Clinical Oncology)
Saturday—9:00 a.m. to 10:30 a.m.
Ellen Sayet, M.D., Fort Myers
Program Chairman

"Present Concepts in the Treatment of Lymphomas," Rodney R. Million, M.D., Professor and Director, Division of Radiation Therapy, University of Florida College of Medicine and Shands Teaching Hospital, Gainesville.
Adjournment

SECTION ON OPHTHALMOLOGY
(Co-sponsored by Florida Society of Ophthalmology)
Saturday—9:00 a.m. to 10:30 a.m.
Giacomo S. Guggino, M.D., Tampa
Program Chairman

"Retinal Detachment with Intraocular Lenses," Raymond J. Sever, M.D., Tampa.
"Six Millimeter Bimedial Recession in Large Angle Congenital Esotropia," G. S. Guggino, M.D., Tampa.
Adjournment

SECTION ON SURGERY
(Co-sponsored by Florida Chapter, American College of Surgeons, and Florida Association of General Surgeons)
Saturday, May 6—9:30 a.m. to 11:30 a.m.
Arthur L. Trask, M.D., Boynton Beach
Program Chairman

"Multiple Systems Failures," Arthur E. Baue, M.D., Donald Guthrie Professor of Surgery and Chairman, Department of Surgery, Yale University School of Medicine, New Haven, Conn.
Discussion
Adjournment

SECTION ON PHYSICAL MEDICINE AND REHABILITATION
(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation)
Saturday—10:00 a.m. to 12:00 noon
Charles J. Kurth, M.D., Orlando
Program Chairman

"Electromyography (EMG): Use and Abuse and Recent Advances," Ernest W. Johnson, M.D., Professor and Chairman, Department of Physical Medicine, Ohio State University College of Medicine, Columbus, Ohio.
Adjournment

(Editor's Note: The following programs were received too late to include chronologically)

FRIDAY — MAY 5

SECTION ON ENDOCRINOLOGY
(Co-sponsored by Florida Endocrine Society)
Friday—8:30 a.m. to 10:15 a.m.
Robert B. Katims, M.D., Miami
Program Chairman

"Problems of Growth and Development in Children and Adolescents," Raphael Bejar, M.D., Clinical Associate Professor of Pediatrics, University of Miami School of Medicine, Miami.
"Pituitary Tumors—New Techniques in Diagnosis and Management," Paul Jellinger, M.D., Clinical Assistant Professor of Medicine, University of Miami School of Medicine, Miami.
"Pseudo-Endocrine Disease and Non-Disease," Yank D. Coble, Jr., M.D., Clinical Associate Professor of Medicine, University of Florida College of Medicine (JHEP), Jacksonville.
Questions and Answers
Adjournment

SECTION ON DERMATOLOGY
(SECTION I)
(Co-sponsored by Florida Society of Dermatology)
Friday—4:00 p.m. to 6:00 p.m.
Gerald Weinstein, M.D., Miami
Program Chairman

Roundtable Clinical Discussion—(Open Question and Answer Format with Guest Speakers and Selected Local Dermatologists)
Adjournment

SECTION ON ENDOCRINOLOGY AND NEPHROLOGY
(Co-sponsored by Florida Endocrine Society
and Florida Society of Nephrology)
Friday—2:00 p.m. to 4:30 p.m.
Robert B. Katims, M.D., Miami
John Cunio, M.D., Miami
Program Co-Chairmen

"Treatment of Renal Bone Disease with Newer Vitamin D Analogues," Jack W. Coburn, M.D., Professor of Medicine, UCLA School of Medicine, Los Angeles.
"Hyperparathyroidism—Problems in Diagnosis and Management," Eric Reiss, M.D., Professor of Medicine and Vice Chairman, Department of Medicine, University of Miami School of Medicine, Miami.
"Non-surgical Management of Hyperparathyroidism," Peter Weissman, M.D., Clinical Assistant Professor of Medicine, University of Miami School of Medicine, Miami.
Questions and Answers
Adjournment

SATURDAY — MAY 6

SECTION ON DERMATOLOGY
(SECTION II)
(Co-sponsored by Florida Society of Dermatology)
Saturday—8:30 a.m. to 1:30 p.m.
Gerald Weinstein, M.D., Miami
Program Chairman

Presentations by Residents in Dermatology
Guest Lecture—(To Be Announced)
Coffee Break
First Wiley Sames Lectureship—Mitchell Sams, M.D., Professor of Dermatology, University of North Carolina School of Medicine, Chapel Hill, N. C. (Topic To Be Announced)
Presentations by Residents in Dermatology
Scientific Dermatopathology Session—Tobias Funt, M.D., Ft. Lauderdale, Fla.
Adjournment

Tenth Teaching Conference In Clinical Cardiology

Emphasis: Problems Commonly Seen in Clinical Practice including Bedside Diagnosis, Coronary Artery Disease, Hypertension, Valvular Heart Disease, and Current Concepts in Therapy.

Special Features: THE CARDIOLOGY PATIENT SIMULATOR (ANIMATED MANIKIN) will be used extensively to present a variety of "patients" including all bedside findings, arterial and venous pulses, precordial movements and auscultation. Review of the newest practical concepts in evaluation and management of angina and myocardial infarction from initial symptoms and acute care through the effect of stress and the current status of rehabilitation after infarction. We shall also feature group patient examination with audiophones, E C G interpretation sessions, abstract book with self assessment exam, and updated Self Learning Laboratory sessions.

Guest Professors: Leonard S. Dreifus, M.D., Chief, Cardiovascular Dept., Prof. of Medicine, Jefferson Medical College, President-elect, American College of Cardiology; Robert S. Eliot, M.D., Director, Cardiovascular Division, Prof. of Medicine, University of Nebraska, Chairman, Board of Governor's, American College of Cardiology; Charles E. Rackley, M.D., Director, Specialized Center of Research in Ischemic Disease, Prof. of Medicine, University of Alabama Medical Center; Pravin H. Shah, M.D., Chief, Division of Cardiology, Wadsworth Veterans Administration Hospital, Los Angeles, California.

Course Approval: As an organization accredited for Continuing Medical Education, the University of Miami School of Medicine certifies that this Continuing Medical Education offering meets the criteria for 31 prescribed hours by the American Academy of Family Physicians.

Sponsored By: The University of Miami School of Medicine and the Council on Clinical Cardiology of the American Heart Association.

Dates: March 22-25, 1978.

Location: The Americana Hotel of Bal Harbour, 9701 Collins Ave., Miami Beach.

For Information Write: Michael S. Gordon, M.D., Professor of Medicine, Program Director, University of Miami School of Medicine, Section of Cardiology, P.O. Box 520875, Biscayne Annex, Miami, Florida 33152. Telephone number: (305) 547-6491.

Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Handbook of Obstetrics and Gynecology, 6th Edition, by Ralph C. Benson, M.D. 772 Pages. Illustrated. Price $9.50. Lange Medical Publications, Los Altos, Calif., 1977.

The sixth edition has been updated in many areas and is an excellent, concise, compact handbook of the knowledge of obstetrics and gynecology. While the book is primarily aimed at the medical student, nurse-midwife, and the busy general practitioner, the specialist will enjoy its concise review of the field.

I did not read the previous edition so cannot compare all areas, but I noted several areas that have not been updated. For instance, little is said regarding ultrasonography which is becoming an increasingly necessary tool in obstetrics. In the management of the pregnant diabetic, he does not mention the usefulness of ultrasonography, the oxytocin challenge test, or amniocentesis for fetal maturity in timing the delivery of the gravid diabetic. On the other hand, the section on psychosomatic problems in gynecology nicely puts together a lot of material that I have not read in other texts and makes interesting reading. New topics have been added: the low birth weight neonate, amniotic fluid embolism, menstrual regulation, rape, premarital counselling, hysteroscopy, colposcopy, and neonatal surgical emergencies. The sections on sexually transmitted diseases and menopause have also been revised.

It is well indexed, and a moderate number of useful tables are presented. The Handbook has been reprinted in several languages which is a tribute to its success, and I recommend its inclusion in the physician's personal library because of the book's concise overview of the field.

Robert E. McCammon, M.D.
Tampa

Dr. McCammon is a practicing Obstetrician-Gynecologist in Tampa

Insurance Handbook for the Medical Office by Marilyn T. Fordney. 646 Pages. Price $12.95. Illustrated. W. B. Saunders Company, Philadelphia, 1977.

Do you have any difficulty instructing your insurance clerk? If so, perhaps this handbook will be of help to you and your office staff. Mrs. Fordney has designed the book for use in the classroom as well as the individual office. Chapters are concise. Frequent, well chosen illustrations are used. Each chapter has a section of review questions.

A well chosen bibliography is available.

This book can be recommended as a guide for the physician's office staff.

F.N.V.

Together: A Casebook of Joint Practices In Primary Care by Hal Higdon, Ron Offen and Jack Starr. 257 pages. Price $5.95 (soft cover). NJPC Epic, 7383 Lincoln Avenue, Chicago 60646, 1977.

This soft bound book produced by National Joint Practice Commission gives brief histories in magazine style of 24 instances of joint practice by a physician and nurse practitioner. The recurring theme in these cases is better satisfaction in type and style of practice by patient, nurse practitioner and physician. The articles also stress some of the difficulties in initiating this type of practice-legal problems, overcoming physician resistance to innovative modes of practice. The major appeal of this book will be limited to physicians and nurses contemplating this type of joint practice.

F.N.V.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Healthy Pregnancy — The Yoga Way by Judi Thompson (Foreword by James C. Baker, M.D.). 148 Pages. Illustrated. Price $3.95. Doubleday & Company, Inc., Garden City, New York, 1977.

BT Behavior Therapy, Strategies for Solving Problems in Living by Spencer A. Rathus, Ph.D., and Jeffrey S. Nevid, Ph.D. 314 Pages. Illustrated. Price $8.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Labor & Delivery, An Observer's Diary by Constance A. Bean with an introduction by Gerald Cohen, M.D., 203 Pages. Price $7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Controlled Substances Inventory List, by the United States Department of Justice, Drug Enforcement Administration, 293 Pages. Washington, D.C., 1977.

General Ophthalmology, 8th Edition, by Daniel Vaughan, M.D., and Taylor Asbury, M.D. 379 Pages. Illustrated. Price $12.00. Lange Medical Publications, Los Altos, California, 1977.

The Nervous System by William F. Ganong, M.D., 226 Pages. Illustrated. Price $8.00. Lange Medical Publications, Los Altos, California, 1977.

Handbook of Pediatrics by Henry K. Silver, M.D., C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 723 Pages. Price $9.00. Lange Medical Publications, Los Altos, California, 1977.

Nothing to Fear, Coping With Phobias by Fraser Kent. 204 Pages. Price $7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Modern Cardiology by John D. Cantwell, M.D. 468 Pages. Illustrated. Price $24.95. Butterworths, Woburn, Massachusetts, 1977.

Human Nervous System by Gary B. Dunkerley, Ph.D. 216 Pages. Illustrated. Price $5.50. F. A. Davis Company, Philadelphia, 1977.

Clinical Cardiology by Maurice Sokolow, M.D. and Malcolm B. McIlroy, M.D. 659 Pages. Illustrated. Price $16.00. Lange Medical Publications, Los Altos, California, 1977.

INFORMATION FOR AUTHORS

Manuscripts should be submitted to the Editor of the Journal, Florida Medical Association, P.O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of senior author.

Synopsis-Abstract. All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes your article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to **Index Medicus,** volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publications should be designated "For Publication."

Our new Medical Necessity Program has two worthy goals:

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2. Radical Hemorrhoidectomy, Whitehead Type
3. Omentopexy — Portal Obstruction
4. Kidney Decapsulation, Unilateral and Bilateral
5. Perirenal Insufflation
6. Nephropexy
7. Circumcision, Female
8. Hysterotomy
9. Supracervical Hysterectomy
10. Uterine Suspension
11. Uterine Suspension with Presacral Sympathectomy
12. Hypogastric or Presacral Neurectomy
13. Fascia Lata by Stripper — when used to treat lower back pain
14. Fascia Lata by Incision — when used to treat lower back pain
15. Ligation of Femoral Vein, Unilateral and Bilateral — when used to treat Post Phlebitic Syndrome
16. Excision of Carotid Body Tumor — when used to treat Asthma
17. Sympathectomy, Thoracolumbar, Unilateral or Bilateral — when used to treat Hypertension
18. Sympathectomy, Lumbar — when used to treat Hypertension
19. Basal Metabolic Rate — BMR
20. Protein Bound Iodine — PBI
21. Icterus Index
22. Ballistocardiogram — BCG
23. Phonocardiogram with Interpretation and Report
24. Angiocardiography, using Carbon Dioxide, Supervision and Interpretation Only
25. Angiocardiography, Single Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
26. Angiocardiography, Multi-Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
27. Angiography — Coronary, Unilateral, Selective Injection, Supervision and Interpretation Only, Single View unless in an Emergency
28. Angiography Extremity

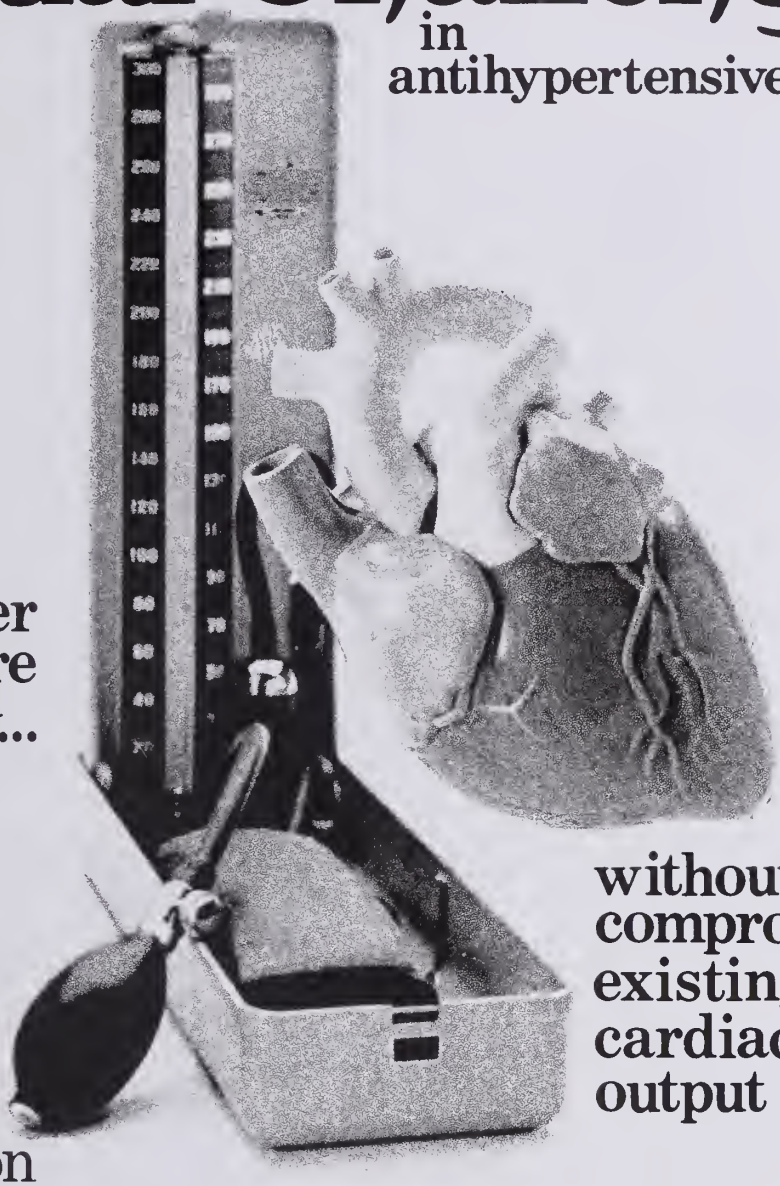
This program was developed in cooperation with The American College of Physicians, The American College of Surgeons and The American College of Radiology. We ask your support in making our Medical Necessity Program 100% effective.*

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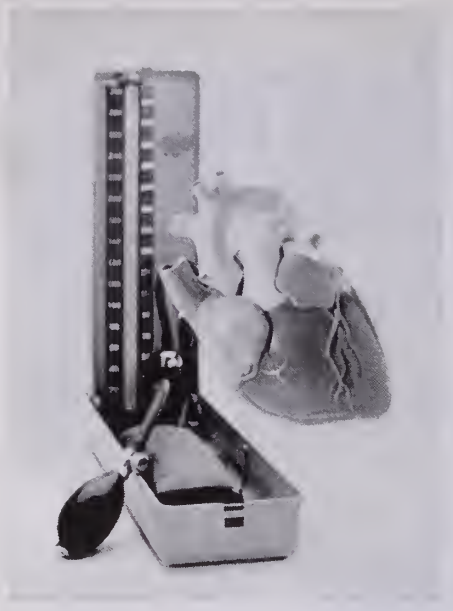
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ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.
It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

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Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

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Vasodilan–compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg.(1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836



VASODILAN® 20-mg tablets

(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

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Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.
Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.
How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

FEBRUARY

Hematopathology, Feb. 1-3, Tampa+

Twelth Annual Symposium on Cosmetic Surgery, Feb. 2-4, Cedars of Lebanon Hospital, Miami. For information: Thelma MacGregor, Seminar Sec., Cosmetic Surgery Symposium, Cedars of Lebanon Hospital, 1400 N.W. 12th Avenue, Miami 33136.

Florida Cleft Palate Association Annual Meeting, Feb. 3-4, Konover Hotel, Miami Beach. For information: William Silver, M.D., 6950 North Kendall Drive, Miami 33156.

23rd Central Florida Medical Meeting, Feb. 3-5, Contemporary Resort Hotel, Orlando. For information: Edward Ackerman, M.D., 800 West Morse Blvd., Winter Park 32789.

Management of Cardiac Disease—1978, Feb. 3-5, Omni International Center, Miami. For information: Robert J. Myerburg, M.D., and Agustin Castellanos, Jr., M.D., Division of Cardiology, University of Miami, P.O. 520875, Miami 33152.

Cardiology at Marina Bay, Feb. 3-5, Broward General Medical Center, Fort Lauderdale. For information: H. R. Cooper, M.D., 1600 South Andrews Ave., Fort Lauderdale 33316.

South Florida Psychiatric Society Annual Symposium, Feb. 4, Dupont Plaza Center, Miami. For information: Doris Shellow, P.O. Box 331266, Miami 33133.

Fourth Annual Vail Conference in Anesthesiology, Feb. 4-11, Miami.*

OB-GYN Caribbean Seminar, Feb. 4-11, Miami.*

Symposium "Your Dying Patient," Feb. 5, Fontainebleau Hotel, Miami Beach.*

Thirteenth Annual Postgraduate Course—Internal Medicine 1978, Feb. 5-10, Sheraton Four Ambassadors Hotel, Miami. For information: J. Bocles, M.D., University of Miami School of Medicine, Department of Internal Medicine, P.O. Box 520875, Miami 33152.

Clinical Nephrology and Hypertension, Feb. 6-8, Doral Beach Hotel, Miami. For information: Office of CME Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

Florida Midwinter Seminar in Ophthalmology, Feb. 6-8, Miami.*

13th Annual "Internal Medicine 1978," Feb. 6-11, Miami.*

Florida Midwinter Seminar in Otolaryngology, Feb. 9-11, Miami.*

Internal Medicine Update '78, Feb. 13-18, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D. or Samuel E. Crockett, M.D. or Roy Behnke, M.D., 1416 S. Orange Avenue, Orlando 32806.

Third Midwinter Seminar in Obstetrics and Gynecology, Feb. 16-18, University of South Florida, Tampa 33606+

***For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

Basic Clinical Electrocardiography and Arrhythmia Management, Feb. 17-19, Bahia Mar, Fort Lauderdale. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

Fourth Annual Pediatric Surgical Postgraduate Course, Feb. 23-25, Konover Hotel, Miami Beach. For information: Malvin Weinberger, M.D., 6125 Southwest 31st St., Miami 33155.

Pediatric Dermatology Seminar, Feb. 23-26, Konover Hotel, Miami Beach. Program to be followed by a one week post seminar flight and cruise to the Caribbean and South America. For information: Guinter Kahn, M.D., 16800 N.W. 2 Ave., Suite 401, N. Miami Beach 33169.

Short Course in Objective ENT Test Procedures, Feb. 24-26, Mercy Hospital, Miami. For information: Fredric W. Pullen, II, M.D., 3661 South Miami Ave., Suite 310, Miami 33133.

Basic Neurology for Psychiatrists, Family Practitioners and General Practitioners, Feb. 26-Mar. 3, Miami.*

Initial Management of the Pediatric Emergency, Feb. 27-Mar. 2, Americana Hotel, Miami Beach. For information: Emergency Medical Services Symposia, Inc., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

Consultations in Clinical Gastroenterology, Feb. 28-Mar. 1, Miami. For information: CME Coordinator, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

Symposium: Nutrition Throughout the Human Life Cycle, Feb. 28-Mar. 2, Tampa.+

MARCH

Urinary Incontinence in Women, Mar. 1, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Hepatobiliary Disease in Clincial Practice, Mar. 2-4, Miami.*

5th Annual Selected Topics in Urology, Mar. 2-4, Gainesville Hilton, Gainesville.**

First International Congress on Colonoscopy and Disease of the Large Bowel, Mar. 2-4, Fontainebleau Hotel, Miami Beach. For information: John P. Christie, M.D., 7400 N. Kendall Drive, Suite 311, S. Miami 33156.

Perinatology II High Risk Pregnancy Conditions and Their Management, Mar. 2-4, Hyatt House, Orlando. For information: Amelia C. Cruz, M.D., University of Florida College of Medicine, Department of Obstetrics and Gynecology, Box J-294, JHMHC, Gainesville 32610.

Problems in Rheumatology, Mar. 2-5, Don CeSar Beach Resort Hotel, St. Petersburg Beach. For information: Bernard F. Germain, M.D., University of South Florida, Tampa 33620.

Management of Diabetes Mellitus, Mar. 3, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

3rd Annual Conference in Skin Disorders for Nurses, Mar. 3-5, Miami.*

Modern Management of Common Skin Disease, Mar. 3-5, Carrillon Hotel, Miami Beach.*

Postgraduate Seminar in Dermatology, Mar. 3-5, Miami.*

Eighth Annual Radiological Special Procedure Seminar, Mar. 4-7, Konover Hotel, Miami Beach. For information: Mrs. Lucy Kelley, 6752 S.W. 34th Court, Miramar 33023.

Gateway Cancer Symposium, Mar. 6-8, Orlando Hyatt House, Kissimmee. For information: Charles Taylor, 1001 S. MacDill, Tampa 33609.

Mediclinics 1978, Mar. 6-17, Galt Ocean Mile Hotel, Fort Lauderdale. For information: Donald R. Lannin, M.D., 832 Central Medical Building, St. Paul, Minnesota 55104.

16th Annual Clinical Radiology Seminar "Controversies in Radiology," Mar. 7-11, Konover Hotel, Miami Beach. For information: Mrs. Lucy Kelley, 6752 S.W. 34th Court, Miramar 33023.

GYN Seminar, Mar. 9, Mercy Hospital Conference Center, Miami. For information: James Jude, M.D., 3663 South Miami Ave., Miami 33133.

Symposium on Ocular Trauma, Mar. 11, Tampa.+

2nd Annual Seminar "Special Aspects of Computed Tomography, Mar. 12-15, Konover Hotel, Miami Beach.*

Invasive Cardiological Techniques, Mar. 13, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Mar. 13-18, Miami.*

Respiratory Management: 1978, Mar. 13, 20 & 27, simultaneously at Broward General Medical Center, Mt. Sinai Medical Center and South Miami Hospital, Miami. For information: Adam Wanner, M.D., 830 Brickell Plaza, Miami 33131.

Practical Aspects of Ultrasonography, Mar. 15-18, Konover Hotel, Miami Beach.*

A Look Forward: Recent Advances in Emergency Medicine, Mar. 16-19, Omni International Hotel, Miami. For information: Registrar, Sixth PGS, 600 Courtland St., Suite 420, Orlando 32804.

Infectious Disease and Immunology, Mar. 17-18, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D. or Samuel E. Crockett, M.D., 1416 South Orange Avenue, Orlando 32806.

Clinical Family Planning for Physicians, Mar. 20-21, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Current Clinical Concepts in Otolaryngology, 1978, Mar. 22-24, Miami.*

Tenth Teaching Conference in Clinical Cardiology, Mar. 22-25, Americana Hotel, Miami Beach. For information: Michael S. Gordon, M.D., Ph.D., University of Miami School of Medicine, Division of Cardiology, P.O. Box 520875, Biscayne Annex, Miami 33152.

9th Annual Topics in Internal Medicine, Mar. 23-25, Gainesville Hilton, Gainesville.**

Seminar for Chronic Pain, Mar. 31-Apr. 2, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

APRIL

Malignant Hyperthemia, Apr. 6-9, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 10-15, Miami.*

Fifth Annual Scientific Session, Apr. 11-14, Hilton Hotel, Jacksonville. For information: Charles L. Gaudry Jr., M.D., Department of Family Practice, Naval Regional Medical Center, Jacksonville 32201.

Basic ECG for the Primary Physician, Apr. 13-16, Hyatt Regency Hotel, New Orleans. For information: Caral Sparks, EMSS, 3900 N.W. 79th Ave., Miami 33166.

Obstetric Anesthesia—Fourth Annual Seminar in Memory of Virginia Apgar, M.D., Apr. 14-16, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Sixth Annual Intensive Care Symposium, Apr. 15-17, Miami.*

Emergencies in Internal Medicine, Apr. 17-20, Miami.*

Advanced Electrocardiography and Arrhythmia Management for the Family Practitioner, Apr. 20-22, Gainesville Hilton, Gainesville.

ENG Seminar and Workshop, Apr. 28-29, Orlando. For information: Frederic W. Pullen, II, M.D., 3661 South Miami Ave., Suite 310, Miami 33133.

MAY

Second Annual Symposium on Underwater Medicine, May 4-8, Miami.*

Seizure Disorders, May 5, VA Center, Bay Pines. For information: John C. Gallagher, M.D., Chairman, Education Committee, VA Center, Bay Pines 33504.

Newer Clinical Perspectives in the Management of Myocardial Infarction and Coronary Artery Disease, May 5-6, 1978. Carefoot Beach Inn/Sheraton Motor Inn, Panama City Beach. For information: Ernest G. Haslam, M.D., Post Office Box 491, Panama City 32401.

Oncology in Community Practice, May 8, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.

Post-Convention Seminar and Diving Program, May 8-11, Miami.*

Orthopedic Seminar, May 11, Mercy Hospital Conference Center, Miami. For information: James Jude, M.D., 3663 South Miami Ave., Miami 33133.

Pars Plana Vitreous Surgery-The Miami Technique, May 11-13, Miami.*

Clinical Family Planning for Physicians, May 15-16, University Hospital, Jacksonville For information: James A. O'Donnell, M.D., 655 West 8th St., Jacksonville 32209.

Family Medicine Update—1978, May 18-21, Miami.*

7th Family Practice Review, May 22-26, Gainesville Hilton, Gainesville.**

JUNE

Review Course for Certification in Internal Medicine, June, Miami.*

The Private Practice of Psychiatry, June 8, Mercy Hospital, Miami. For information: Bernard Tumarkin, M.D., 3663 South Miami Ave., Miami 33133.

Bascom Palmer Eye Institute Alumni Meeting and Seminar, June 9-11, Miami.*

Florida Suncoast Pediatric Conference, June 12-14, Sheraton Sand Key, Clearwater. For information: Donald I. Macdonald, 1510 Barry Street, Clearwater 33516.

Coronary Disease, Exercise Testing and Cardiac Rehabilitation, June 23-25, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

JULY

Examination of the Arterial System, July 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.

SEPTEMBER

Transient Ischemic Attacks; The Computerized EEG, Sept. 11, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.

NOVEMBER

Adolescent Medicine, Nov. 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.



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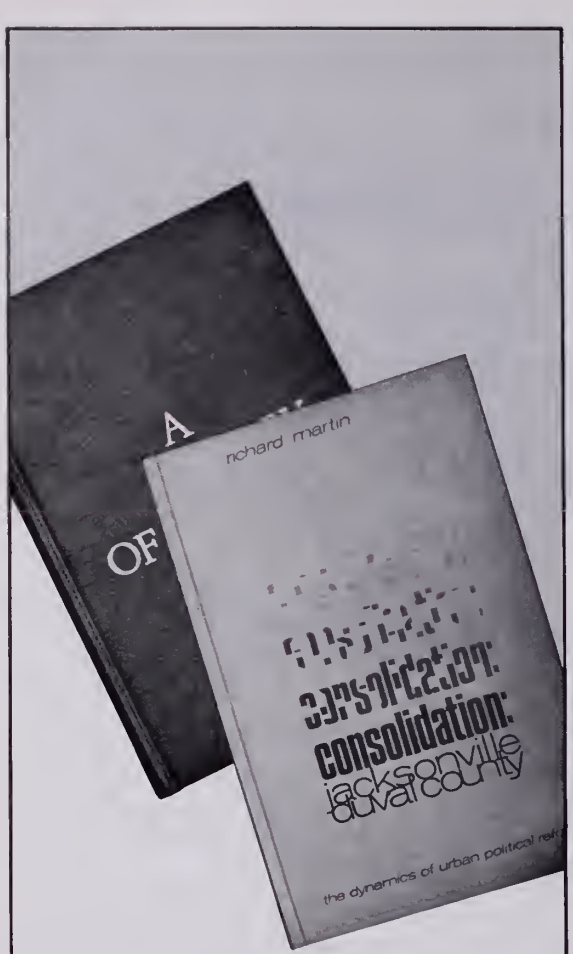
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ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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Please see brief summary of prescribing information on facing page

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Kaon® Elixir
(potassium gluconate)

Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

Time is the test of all things

1954
1977



tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

KAON® (potassium gluconate) ELIXIR

Description: Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

Indications: See Kaon Tablets.

Precautions: See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

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Provides guidelines and general principles to help you determine the criteria for selecting a medical office that best suits your needs. Includes: basic planning before building; office construction, inside and out; your office interior; office condominiums.

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8 **New Doctor's Kit** (OP-458) $10.00
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9 **Group Practice Kit** (OP-457) $7.50
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Gene H. Stollerman, M.D., Professor and Chairman, Department of Medicine, University of Tennessee, College of Medicine, Memphis TN.

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The Learning Center consists of fully automatic synchronized cassette/slide projection of lectures. This center will be available during the evenings.

Audio Visual Aids

Audio visual teaching aids (television sets with tape players, slide projectors synchronized with cassette tapes and guides) will be available during the entire meeting for self instruction and reinforcement.

Exhibits

Scientific and Technical Exhibits will be shown daily.

SUPERVISED CME ACTIVITIES: 35 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that this continuing medical education offering meets the criteria for 35 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed. Approval by the American Academy of Family Physicians for prescribed hours will be applied for.

SELF-INSTRUCTIONAL MATERIALS: 25 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that when these continuing medical education materials are used as directed, they meet the criteria for 25 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association.

Registration: $350—Physicians $200*—Physicians in training
*Letter from Chief of Service must accompany registration.

For Registration and Information write to: J. Bocles, M.D., Department of Medicine, University of Miami School of Medicine, P.O. Box 520875, Miami, Florida 33152. Phone: (305) 547-6063.



Others Are Saying

Random Thoughts

If the amount of literature which daily comes over our desks is any indication, the current "in thing" appears to be concern with "Death and Dying." Every week we are told about seminars on "The Care of the Dying", "The Terminally Ill Patient", "Death with Dignity", "Living Wills", "The Right to Die", etc.

In years gone by most people died in their homes, surrounded by their loved ones, and always with a physician close at hand . . . powerless to do anything perhaps, except give the greatest gift of all—himself.

In the not too distant past many physicians, regardless of their specialty, had a number of "terminal patients," for whom death drew closer and closer. These patients were seen in their homes, at the convenience of the physician, often late in the afternoon or on weekends, with some degree of regularity; sometimes at weekly intervals, and then oftener as death came closer.

True, there was nothing done in the present medical sense of the word: "doing something," but these patients were cared for because there was a physician who cared.

It is "progress," or "advancement of our profession," when today so many of our dying patients do so alone in hospitals, isolated, impersonally served by strangers, regimented into various programs of treatment, and hooked up to various "life support" (death-prolonging)? mechanical devices.

How many of us can honestly say we feel comfortable in the presence of the dying. Are there still those left among physicians, in any great numbers, who know the art of "masterful inactivity"—who can sit in the sickroom with the patient patiently and silently, if the patient so desires, and be there to wait and listen, often without the necessity of any comment, to any expressed thoughts which a patient might wish to pour out in the solitude of his illness, enduring these long voids of silence when the dying patient silently communes in spirit with his physician, though no words on some visits are spoken. The patient, as fully aware as the physician that we can do nothing, but as a physician and a human being we are there to make that hour of that day a more pleasant period because we care, and because the patient knows we are there because we care.

To the young physician who faces the dying patient, too often the patient is hospitalized and the care and the caring is delegated—at least it is thought to be delegated. Hospital personnel in ancillary departments, regardless of their skill and empathy, can never replace a physician.

A caring physician with a dying patient shares a great educational experience. Each of us must some day face our own final illness. Every older and more experienced physician can immediately recall numerous examples of dying patients who prepared for their eventual death with a display of acceptance, courage, and equanimity which should be the envy of every physician so fortunate to share this death experience with his patient.

The physician should be especially appreciative of this opportunity to personally care for the dying patient, for in so doing the physician experiences this great educational experience, and the physician can thus prepare himself for his own death, and for the death of members of his own circle of relatives and family. From each patient we care for in their last illness, we have so much to learn and we can be of so much help to the patient.

This is an educational experience which cannot be learned from books, only from physician-teachers, who have been involved in so many death care experiences, having come to terms and mastered their own anxieties so well that such a physician can impart, to a younger colleague following him on death rounds, a valuable teaching experience.

The writer was unusually fortunate in a number of medical centers to be taken into the rooms, and into the homes, of a great number of dying patients being cared for by senior physicians, so that he, as a young physician, might observe this greatest of all physician services—really caring for the dying. Often, the silence for quite long periods of time was quite anxiety-producing, until observed, appreciated, and understood. On many occasions a senior physician would sit, and nothing would be said for long periods of time. The prolonged silence, when first experienced, was awesome, but from those death round visits in the home and in the hospital, oberving such a physician who "cared," thus brought to the patient, to our profession, and to the participating student, a sense of serenity and appreciation of personal doctor-patient relationships which defy description.

How many of us make it an absolute must to always go to the hospital, or to the home, when one of our patients die? To be there with the family, regardless of the time of day or night when death occurs; regardless of how long the patient has been ill? To drink coffee with the relatives, to sit with them, to put our arms around grieving family members and say: "I cared, too." Each of us should learn to give to our patients such evidence we care; that their loss is also our loss—for with each patient who dies, after our best efforts, the patient has meant something to us and we should never be ashamed to say that we, too, cared and will miss that beloved patient we got to know so well during life's last journey. The only thing we ever have is that which we give away, a part of our own life.

P.S. (Do you think such a physician cares if he has malpractice insurance?)

James J. Crumbley, M.D.
Tampa

Reprinted from the Editors' Column in The Bulletin of the Hillsborough County Medical Association, February 1977.

Newspaper Series Well Done

A series of twelve features highlighting extensive medical and surgical treatment was published in the Pensacola News-Journal. One such feature was published each Sunday for the duration of the series. A unique facet of this series is the agreement between the Medical Society and the newspaper that the anonymity of the hospital and the physician would be preserved. The patient's privacy could be preserved or not, at his own discretion. The anonymity issue was an interesting one. Journalistic tradition has it that all sources should be identified wherever possible. As one newspaper has put it, "you got to hang the noose around someone's neck." Never before, locally, had there been shown by the press the respect for anonymity which most physicians prefer; Yet, in suggesting this series, Mr. Buddy Baker, Managing Editor of the Pensacola News-Journal, indicated that they would respect our wishes. Rather than being a detriment to the story, the anonymity of physician and hospital has pointed to the community service provided by all physicians and hospitals. And it should well be this way. We feel that this break with journalistic tradition is a forward-looking one. This united effort on the part of the two groups has provided a community service for the public of Pensacola and the Northwest Florida area.

After all the vocalized fears when the series first was suggested, the contents of the stories and the photography have been basically non-controversial. There was a whimper here and there but on the whole the reaction of the medical group has been pleasantly receptive. General readership, we understand, has been enthusiastically high.

The features, themselves, have been informative and technically accurate. They have been presented in good taste. From the standpoint of sheer column inches it is unlikely that the activities of any other medical society in the United States has received such an abundance of favorable publicity. All this comes at a time when newspapermen and doctors are having problems in other counties of the state. The Miami Herald has complained that one county society has gagged its doctors, and physicians in that area are most concerned with the doctor-press relationship—concerned to the point that a wall has been erected between the two groups. Perhaps some of the more sophisticated publications and medical specialists could find a good example up here in the Panhandle of Florida in how to avoid self-advertising and at the same time provide helpful information to the public.

At the beginning there were doubts that the project would ever meet fruition. The first reaction of the Executive Committee was negative. The proposal violated the medical concept of non-advertising of practitioner and procedure, it would be unethical. And on the other side, the eternal journalistic fear was that someone other than an editor would tamper with the copy. Then members of the Public Affairs Committee sat for a working conference with representatives of the newspaper. In this face-to-face setting, concerns of both groups were placed on the table. Basic medical fear was expressed: Promotion of the physician, the procedure and the hospital. Then there was concern with the misquote, the highlighting of the sensational which would leave a technically incorrect impression.

On the other side of the table, the news persons were fearful of the doctors tampering with the copy, destroying the freshness of a paragraph, the punch of a tight sentence. Once convinced of the merits of the proposal, members of the Public Affairs Committee went to the Executive Committee to speak in behalf of the project. There was opposition, but the position of the Public Affairs Committee in the end prevailed.

Reporters and photographers were sanitized and turned into the operating room. They did their jobs as professionals. No physician received self-advertisement; No hospital was spotlighted; No procedure was given preference over others proved equally effective, ethical privacy was maintained, and West Floridians got a first hand look into what happens to many of them in the operating room and elsewhere in the hospital.

The newspaper most likely will enter the series in some sort of editorial competition for honors. Likewise, the Public Affairs Committee will attempt to attract the attention of the Florida Medical Association and the American Medical Association as to what's happened here in the Panhandle of Florida—and should be happening elsewhere.

Reprinted from The Bulletin of the Escambia County Medial Society, April 1977.

Mr. John McMullen, Executive Editor
Miami Herald

Dear Mr. McMullen:

It truly is a paradox of modern society when a so-called responsible newspaper such as the Miami Herald can, without any qualms whatsoever in large headlines on 3/15/77, make a blatantly false statement that impugns the character and morals of physicians by implying fraud and dishonesty of the one segment of our society that gives more free care to society than any other. Even though in smaller print below you try to be more truthful — the damage and impact that you wanted to make against us is made. Any truly responsible organization would be ashamed of itself.

Physicians traditionally back through the years, from their first days on the wards of hospitals, spend their days and nights, day after day, rendering free care to those unable to pay, studying, learning, teaching and caring while undergoing one of the longest and most demanding training programs known to man. We do this at a terrific sacrifice in time to our families. The cost has become almost prohibitive and by the time we finish many of us are head over heels in debt with all of the expenses of an office, secretaries, nurses, and the outrageous malpractice premiums.

Why is it so immoral, as implied, for a physician to earn in proportion to that training and the number of hours he works? He is on call long hours, up and operating frequently in the middle of the night. His time rarely is his own or his family's.

The football players who make this type salary are very plentiful and are national heroes, yet it is implied the physician has to be dishonest and cheat to earn the same amount of money. This is very wrong. In our society, a person who wants to work hard, study hard and move ahead has always been allowed to and encouraged to do this. Why not the physician also, I ask, if he earns it honestly?

The important emphasis I want to make is that most of these 400 physicians received checks generated by many physicians in groups, clinics and partnership setups—not a solo type practice. Some may be in the latter group, but that number is very small when you consider the number of doctors in the state, over 10,000, and many, many thousands in the nation.

As has been stated many times by the AMA, if fraud has occurred then prosecute just like any other citizen. All of us feel strongly that fraud should be treated harshly and speedily when it is present regardless of who it is, but to indict an entire profession because a relatively few physicians are able to generate this amount is wrong.

To top it all off, a physician in Rhode Island listed as making $307,452,00 in Medicare fee payments in 1975, was told by the Federal Government they made a mistake. He got $625,00, but today's Herald, 3/16/77, prints this retraction on page 8A in a small paragraph where few will see or notice.

The implications and innuendos of dishonesty and fraud can destroy faith and confidence which is so critical in our patient care. It is totally out of proportion to the actual problem and should be stopped.

Charles F. Tate Jr., M.D., President
Dade County Medical Association
Miami

Reprinted from Miami Medicine, April 1977.

We Have Met the Enemy

Some years ago, Walt Kelly created the comic strip Pogo, a gentle satire on humanity using the Okeefenokee Swamp animals as character types in which Pogo the lead character is a possom (o'possum to you purists). Avid fans will recall from the strip such gems as "we have met the enemy and he is us."

In one memorable series Churchy, the turtle, got his head caught inside his shell and despite all his efforts could not dislodge it. His friends contrived various plans. Albert the alligator, an inveterate cigar addict, felt that repeated exhalation of cigar smoke into the shell might provide relief and that if not, he would be willing to sacrifice a lighted cigar inside. Howland Owl was certain that more vigorous measures were indicated and proposed a lighted firecracker. Understandably these approaches were resisted by the victim.

Porky, a somewhat dour porcupine, who possessed remarkable insight into his friends, was consulted. After looking deeply into the space no longer occupied by Churchy's head, he walked away with his hands clasped behind his back but said nothing. Pressed for an opinion regarding what action should be taken, he observed "if he couldn't handle turtling, he ought not to have tuk it up."

Perhaps there is a message for us. Our patients hope and expect us to be interested in them, understanding their foibles, patient with their ignorance, helpful with their anxieties, and available. The impenetrable wall of receptionists and nurses in our offices, the unreturned calls, the unlisted home telephone — aren't all of these a failure to accept this "turtling" which is such an essential part of our profession? Our willingness to be available to the human needs of those who seek our help is a major part of our problem with malpractice, declining public image and attacks from all sides. It may be that we "have met the enemy" and that at least in part "he is us."

Thomas E. McKell, M.D.
Tampa

Reprinted from "The President's Page," Hillsborough County Medical Association Bulletin, March 1977.

Pearly white mound with the rat-bite center
Silent, painless, growing slowly
Cells released from their restraints by many a summer's sun
Spreading roots and tentacles to encircle nearby tissue

BASAL CELL CARCINOMA

F. N. V.

Modern Medical Ethics

Its probably true that basic ethics in any profession should be fairly rigid and permanent. There should be deviations from this rigid code only when justice is blurred by the exigencies of the circumstances or by innovations in procedures. Medical ethics have been particularly buffered and bounced around over the last half century by changes in new concepts in training of physicians and by changes in medical care.

The Hippocratic Oath is still a good foundation for our ethical code. There we should start with the laws of not violating the confidence of our patients, of not taking advantage of intimate relationships and of being conservative in our approach to drastic surgery or medicine.

I would like to discuss rules of ethics for the modern practicing physician in several categories.

I. **Regarding Medical Records**

1. Release records freely on patients' requests.
2. Keep all medical records up-to-date and available.
3. Do not defer reports of injuries, treatments and findings to the detriment of the patients' medical and financial progress.
4. Do not exaggerate or minimize extent of injuries or disease which might encourage miscarriage of justice in case of litigation.
5. Do not encourage a patient to seek redress by litigation.
6. Keep current records at your hospitals.
7. Cooperate actively with hospital record rooms by signing all bureaucratic forms until we can get them abolished.
8. Be perfectly honest in indicating necessity for admission, prolonged stay and extensive diagnositc procedures.
9. Do not assume a selfish arrogant attitude in following staff rules regarding medical records.
10. Keep your fellow physicians informed of special pathology, difficult medical problems or interesting discoveries.

II. **Conduct of Consultations**

1. Agree eagerly for consultation requested by a patient or by a competent member of the family.
2. Try to get the patient or his family to select the consultant. If you are asked to make the selection, give them a list from which to choose.
3. Inform the consultant of the status of the case personally when possible.
4. The consultant should immediately write out a report or tell the physician verbally his findings and recommendations. He should write on a consultation form and not in the progress notes. If he is asked to follow the patient, his further notes should be added to the consultation form.
5. A consultant should not write orders on the chart unless asked to do so by the original physician and then only by noting them as verbal orders requested by the primary physician.
6. The physician writing the orders should have full responsibility for the patient and not be contributing to expensive and confusing double jeopardy.
7. The patients' chart should at all times show who is the responsible physician.
8. No bystander physician should be paid except for specific consultations. Avoid concomitant care.
9. Transfer the patient to any consultant who becomes the primary physician giving the definitive care. If a referring surgeon shortens his follow-up post-operative care, his fee should also be truncated.
10. Do not split fees. Surgical Assistants may be paid by the surgeon if the patient has full knowledge of the amount and to whom it is paid.

III. **Rules of Economy**

1. Shorten expensive hospital stays.
2. Avoid strictly diagnostic admissions.
3. Avoid unnecessary diagnostic procedures.
4. Make no profit on medicines in your office.
5. Do not split fees with laboratories.
6. Prescribe the most economical effective drugs.
7. Label drugs for the benefit of the patient, the next physician, and perhaps for your own benefit.
8. Discourage expensive hypochondriasis.
9. Make yourself available to the public. You are a public servant. Do not refuse to publish telephone numbers and use other ruses to avoid working for a living.
10. Do not give instructions to your office personnel designed to frustrate sick people — such as, "the doctor is taking no new patients." Any physician who is in active practice should see new patients to fulfill his obligation to society.

H. L. Harrell Sr., M.D.
Ocala

Reprinted from the Florida Family Physician, Summer 1977.

IF (apologies to Rudyard Kipling)

If I could say - "why" - at my desk - in quiet office bare,
There should be one - a skeleton - with just some bones - no hair;
If I could know all things I learn'd, with memory anatomical
There would not be need - in our fair group - for bones set up quite comical.

If I could wrap my hands around a picture black or colored,
And gain the three dimensional view we'd get from osseous dullard;
If I could move and work and feel the parts that now are still,
The tri-dimensional application would justify the bill.

And on those days when Harry, Ed, and Percival and Smith
Will question shadows on the film and claim that x-ray's myth,
I'll ask my friend the skeleton to show its parts again
Admittedly they're mostly gone - but he might remember when.

With that he'd write a saga true, of close relationship,
Of parts now gone but not forgot - much like the x-ray blip;
He'd tip his hat for all to see and look inside his skull,
Where middle ear and petrous ridge would interest those who mull.

His xyphoid tip would stick right out for all about to see,
For x-ray, as you all well know, this part is not to be.
And there are many grooves and joints which strain and creak and groan,
And patients sometimes like to see the area where they moan.

I find it hard to claim to you - he'll help with productivity,
But symbolism and "cash flow" had never much acclivity.
So finally, in a last request, almighty Board of Judgment,
Despite the wonders of our time, I hope there's not begrudgment.

The bony man is still a sign, a symbol, and a tool
of what we are, and how we're made, in short - a grammar school
That shall not change in our short life if medicine's an art,
For some of us it sits right there - reminding of our start.

James C. Barnett, M.D.
St. Petersburg

Title and explanation: Request for departmental x-ray skeleton and justification thereof.

If the AMA didn't speak for the profession, who would?

Who would speak for the profession on the 2,500 health bills introduced in every Congress? Or the regulations issued by federal agencies?

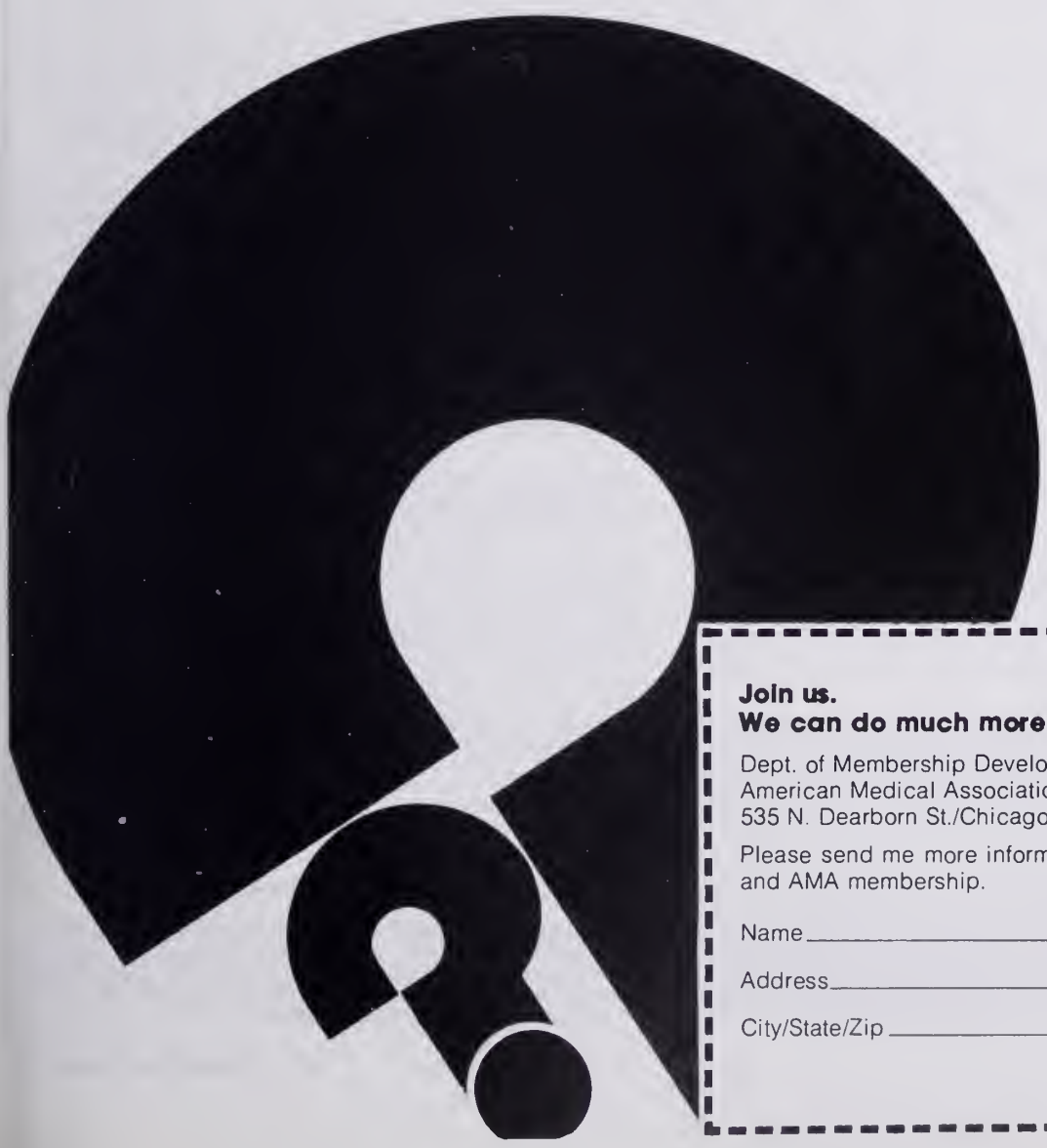
Who would state the profession's views on national health insurance? Utilization Review Regulations? The Health Planning Act of 1974? Maximum Allowable Cost Regulations? Health Manpower?

Who would provide the scientific input and the practitioner's experience and knowledge so essential to legislation on drugs, cancer, heart disease, communicable diseases? Can you think of anyone?

The fact is, there is only one organization that can — and does — speak for the profession as a whole. The AMA.

It does so to protect the basic freedoms of medical practice in any federal health program that might be enacted; and even more important, to promote legislation for better health care for the entire public.

The AMA's voice can only be as strong as the members of the profession choose to make it. With your support, the AMA can be even more effective spokesman.



Join us.
We can do much more together.

Dept. of Membership Development
American Medical Association
535 N. Dearborn St./Chicago, IL 60610

Please send me more information on the AMA and AMA membership.

Name _____

Address _____

City/State/Zip _____

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONERS

FAMILY PRACTICE—Excellent opportunity for physician to perform general practice in expanding North Florida community. Attractive 128-bed new hospital that provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

FAMILY PRACTICE ASSOCIATE WANTED. Possibility of partnership in future. Contact: Ronald M. Thompson, M.D., 6215 South Dixie Highway, West Palm Beach, Florida 33405. Phone: (305) 582-7451.

GENERAL PRACTITIONER: For well equipped medical clinic immediately adjacent to 120 bed skilled nursing facility; would also act as medical director for nursing home. Salary 100% of intake. Contact: Administrator, Wakulla Manor Nursing Home, P.O. Box 508, Crawfordville, Florida 32327. Phone: (904) 926-7181.

FAMILY PRACTITIONER OR INTERNIST WANTED to share facilities with four practitioners in solo practice. Major equipment provided. Rent $250 per month. Competent laboratory and x-ray with income based on use. Bookkeeping system and receptionist shared. Financial assistance available to right party. Contact: T. C. Kenaston Jr., M.D., Box 550, Cocoa, Florida 32922.

PHYSICIAN DESIRED as primary practitioner in new, fully equipped office. Send reply to: C-855, P.O. Box 2411, Jacksonville, Florida 32203.

SPECIALISTS

WANTED — MEDICAL OPHTHALMOLOGIST, primarily for routine exams including refractions. Can be part or full time. Central Florida area. Write C-847, P.O. Box 2411, Jacksonville, Florida 32203.

URGENTLY NEEDED NEUROLOGIST FOR A LARGE MEDICAL COMMUNITY. Opportunity either solo or a joint-existing group. Please send curriculum vitae to C-832, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL-VASCULAR-THORACIC SURGEON, CARDIOLOGIST, FAMILY PRACTITIONER. Immediate openings. Private solo practices, except FP could be partnership. Financial assistance including first year free rent in professional building adjacent to hospital. Contact Claude Weeks, Executive Director, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

URGENTLY NEEDED NEUROSURGEON FOR A LARGE MEDICAL COMMUNITY. Opportunity either solo or a joint-existing group. Please send curriculum vitae to C-832, P.O. Box 2411, Jacksonville, Florida 32203.

WANTED ONCOLOGIST for busy practice. Salary or guarantee to start. No investment needed. Excellent facilities. Name your fee. For information: please call (813) 876-4618.

SEMI-RETIRED CERTIFIED INTERNIST SEEKING WELL QUALIFIED INTERNIST to share fully equipped office in Palm Beach, Florida. All services furnished. No investment required. Send curriculum vitae to C-842, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST: Board certified, with or without specialty, in a five doctor group, with a good opportunity for private practice in a growing area on the west coast of Florida. Write or call Dr. Bernhard J. Weinberg, 241 Nokomis Ave., Venice, Florida 33595. Phone (813) 484-2484 (weekdays) or (813) 485-8856 (evenings).

MISCELLANEOUS

LAMINAR FLOW OPERATING ROOMS tested for conformation to Federal Standard 209-B, also yearly recertification test performed. Contact Jake Truslow Company, P.O. Box E-S, Venice, Florida 33595. Phone: (813) 485-4617.

PSYCHIATRIST/G.P. PHYSICIAN—Openings are anticipated from time to time in well established Community Mental Health Center. Florida license required. This is a CMHC with four large programs: Drug Abuse Alcohol Counseling Center, Child Development Center and General Mental Health Program. Pensacola offers beautiful beaches and excellent recreational opportunities. No state income tax. Letters of inquiry, with resume, should be forwarded to Morris L. Eaddy, Ph.D., Executive Director, Community Mental Health Center of Escambia County, Inc., 1201 West Hernandez Street, Pensacola, Florida 32501. An equal opportunity employer.

UNIVERSITY PHYSICIAN STUDENT HEALTH SERVICES: the University of Florida is seeking a physician experienced in Family Practice, General Practice, and/or Pediatrics, to serve on the Student Health Services staff. Position will require taking calls as necessary and working some weekends. Must possess a medical degree from a recognized medical college. Florida license and board certification preferred. Salary dependent on background and experience. Send complete resume and salary requirements to Robert Willits, Administrative Employment Manager, 207 HUB, University of Florida, Gainesville, Florida 32611. No telephone inquiries please. Equal employment opportunity/affirmative action employer.

Situations Wanted

ORTHOPEDIC SURGEON, 30, married, university trained, available July 1978. Experienced in total joint replacement, desires partnership, group, or solo on Florida coast. American, Bilingual, Spanish-English. Write C-794, P.O. Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST-CERTIFIED CP/AP, 47, Florida licensed, native U.S., excellent C.V. and experience as director. Current post-grad, training and certification through 1980. Write: P.O. Box 11158, U.S. Post Office, 333 E. Ontario St., Chicago, Illinois 60611.

30 YEAR OLD FMG WITH FLEX—ECFMG and Florida license, board eligible, general surgery. Presently doing one year of peripheral vascular surgery. Desires solo, partnership or group. Will consider all locations in Florida. Contact: Antonio Vasquez, M.D., 2799 W. Grand Blvd., Detroit, Michigan 48202.

INTERNIST-ENDOCRINOLOGIST, 30, ABIM certified, university trained. Seeks partnership or group practice in Southeast Florida beginning 7/78. Write C-830, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN: 37 years old; Florida license, board eligible; neonatology subspecialty. Seeks partnership, group or hospital based practice. Desires relocation. Available January 1978. Contact: E. P. Nelson, M.D., 903 Hensley Heights, Man, West Virginia 25635.

THORACIC CARDIOVASCULAR GENERAL SURGEON, now Clinical Professor of Surgery, wishes to transfer practice to Florida. Association or group desired. Hospital full time also considered. Write C-835, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSICIAN, 26 years old, Florida licensed, board certified in pediatrics, with good mastering of English and Spanish, seeks relocation around Ft. Lauderdale area for any type of position part-time or full-time in pediatrics or emergency medicine. Contact: E. Jones, 5350 Arlington Expressway, Apt. 3809, Jacksonville, Florida 32211.

GENERAL AND VASCULAR SURGEON, 35, university trained, board certified, Florida licensed. Seeks practice opportunity, solo, partnership or group. Available 3 months notice. Write C-837, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN, 33 years, university trained, board eligible, available in February 1978, seeks practice opportunity in Florida. Call (304) 583-9592 after 5 p.m.

PEDIATRICIAN—board eligible, clinical and administrative experience in community/ambulatory pediatrics. Desires to join group, preferably university associated. Write C-851, P.O. Box 2411, Jacksonville, Florida 32203.

CLINIC MANAGER, age 40, currently employed—associated with medical groups that have grown from eight to 27 in number. Experienced in all areas. Excellent 10-year growth record. For detailed resume write S. Schutte, 130 Lake Sears Drive, Winter Haven, Florida 33880 or call 1 (813) 293-3369.

POSITION WANTED: PEDIATRICIAN, 28 years, board eligible. Completing neonatology fellowship June 1978. Looking for neonatology position or group practice with emphasis on neonatology. Write C-850, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST/ENDOCRINOLOGIST, 31, ABIM certified, Florida license. Seeks partnership or group practice in Florida. Available July, 1978. Write C-848, P.O. Box 2411, Jacksonville, Florida 32203.

EXPERIENCED PHYSICIAN, G.P., E.R., wishes to join established practice or hospital staff. Contact: Genaro E. del Barrio, M.D., 1155 West 77th St., Apt. 320-C, Hialeah, Florida 33014.

PHYSICIAN ASSISTANT SEEKS two month preceptorship beginning March 9, 1978, leading to full-time employment with family practice group. Fourth year student in the Category 1 A.M.A. rated program will complete BS degree May 1978. Fully qualified in history taking, physical diagnosis, rounding, comprehensive preoperative and postoperative evaluation and followup, assisting in surgery and outpatient coverage in a holistic approach to patient care. Mary Jaycox, P.A., Box 2021, Clarksburg, West Virginia 26301, (304) 623-3461 or John Jaycox, F.S.E.S., Pensacola (904) 432-7651.

PHYSICAL THERAPIST, 36, highly motivated. Florida licensed, interested in partnership with hospital or orthopedic physicians. Ten (10) years excellent experience, heavily geared toward orthopedics. Knowledge of fracture bracing and skeletal traction. Proven clinical and business record. Experience in starting new departments. Interested in a permanent situation. References and resume upon request. Write C-849, P.O. Box 2411, Jacksonville, Florida 32203.

OPHTHALMOLOGIST, 34, completing university glaucoma fellowship June 1978, seeking association or purchase of practice, prefer greater Miami area. Call (212) 427-2915. Alan Kohn, M.D., 305 E. 86th St., New York, N. Y. 10028.

BOARD CERTIFIED INTERNIST, GASTROENTEROLOGY specialty seeking position with income guarantee for July 1978. Rajkumar Warrier, M.D., 68-A Manhattan Court, Brooklyn, New York 11235. Phone: (212) 332-3951.

INTERNIST, 29, ABIM eligible after completing residency. Has ER experience, seeks partnership or group in S. E. Florida. Available July 1978. Write C-852, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST, ABIM, age 29, seeks solo, partnership or small group in metro Miami vicinity. Available now. Reply to C-854, P.O. Box 2411, Jacksonville, Florida 32203.

OPHTHALMOLOGIST, 30; board certified; experienced with intraocular lenses, phacoemulsification and oculoplastics. Seeks solo, group or partnership opportunity or purchase of practice. Has Florida license. Write C-856. P.O. Box 2411, Jacksonville, Florida 32203.

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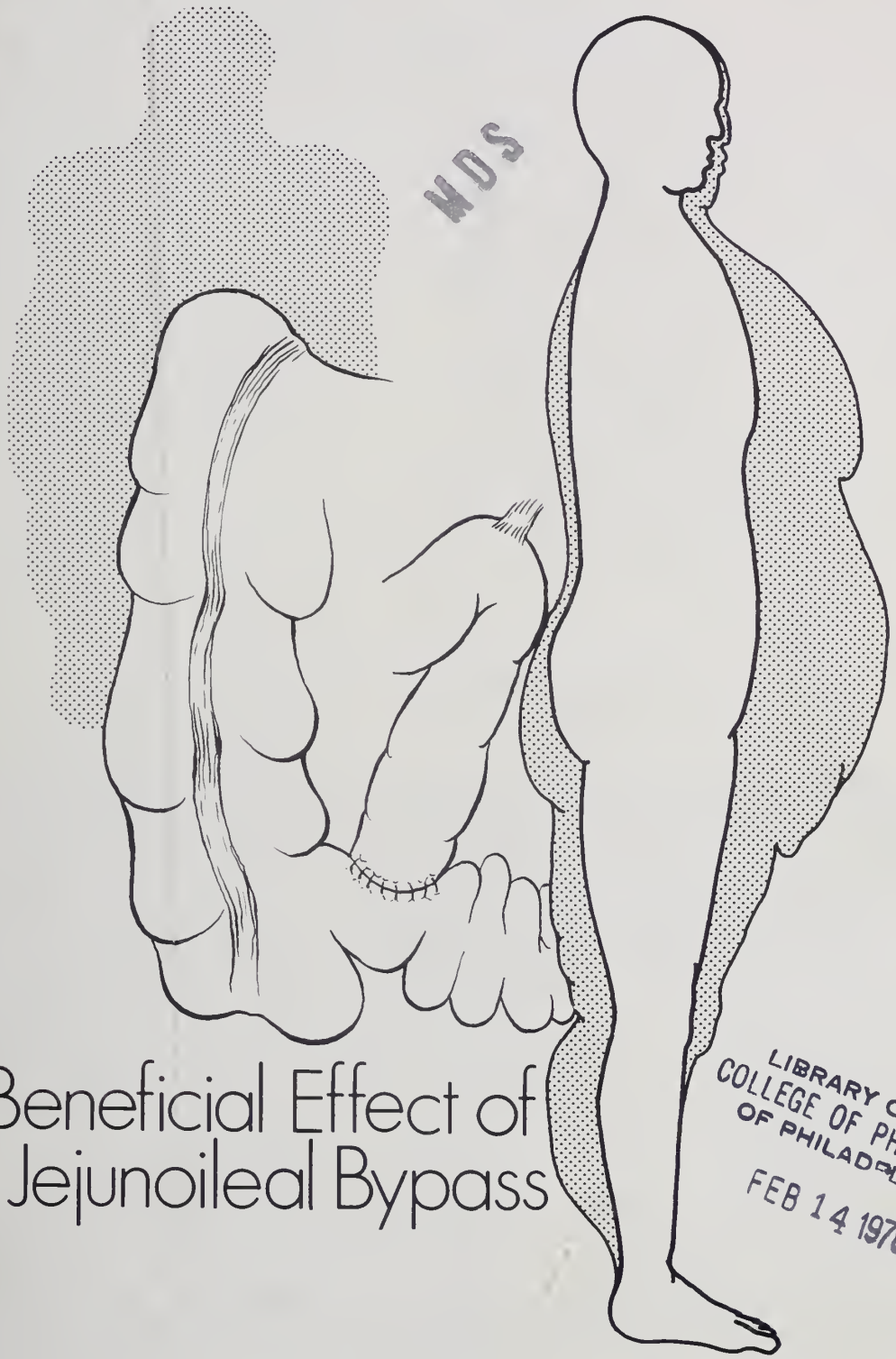
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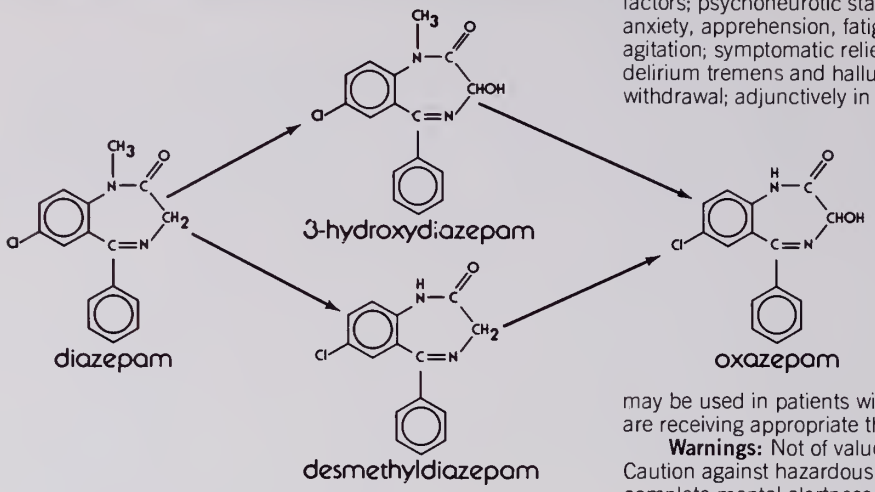
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Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

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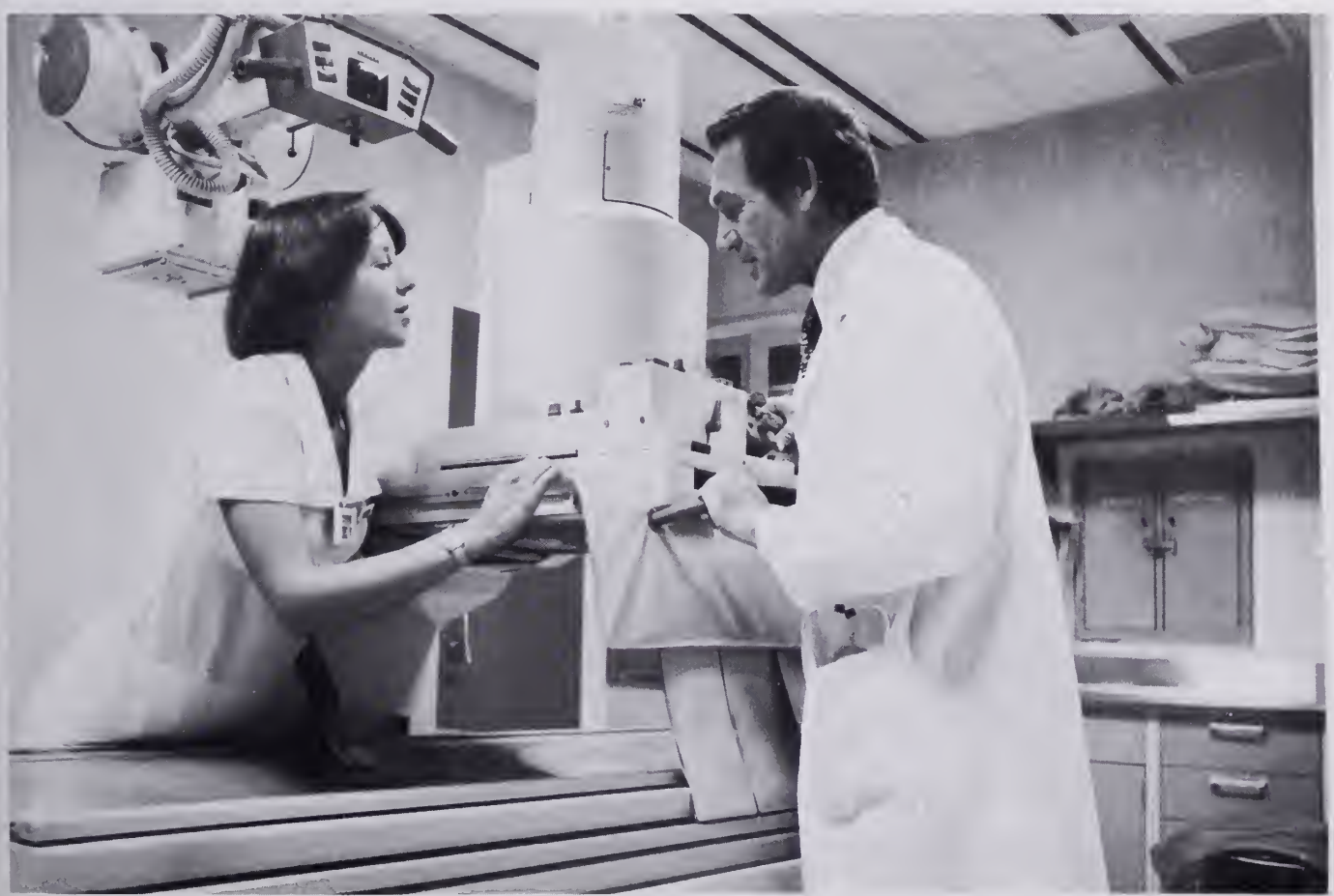
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FEBRUARY COVER — The cover, designed by J. Patrick O'Leary, M.D. and implemented by Debra Neill, demonstrates conceptually the results of the procedure of intestinal bypass as seen by the patients. See lead article, page 95.



Can you have too much of a good thing?

Too much milk, many pediatricians warn, can fill a child up and consequently, can keep him from eating other foods he needs. Particularly, iron-rich foods.

And, of course, that's a major dietary concern.

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Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on:
60 mg tryptophan=1 mg niacin

ndc **National Dairy Council**

Milk. Sometimes we forget all the good things it does.



Dean's Page

Medicaid in Florida

E. M. Papper, M.D.

Medicaid in Florida is in trouble. The projected deficit for the current fiscal year is $19 million. Last year's deficit is still with us. We, as a profession, have the problem and we should and will be part of the solution.

Last October a constructive step toward the solution was taken. Administrators of the Florida Department of Health and Rehabilitative Services, led by Secretary William "Pete" Page, called upon the principal providers and consumers of Medicaid Services in our state to form an ad hoc committee to explore and to recommend substantive action and changes in the state's cooperative program, with local and Federal government, to meet the medical and health care needs of Florida's indigent.

See "Statement on Health Care for the Indigent" on following page.

Every professional state organization involved in the Florida Medicaid Program has been called upon to participate in the proposed reforming of our state government's relationship to the health industry. I am particularly pleased that the Florida Medical Association is playing a key role in these deliberations. Other groups expressing great concern include the Florida Hospital Association, the Florida Health Care Association (nursing homes), the Florida Pharmaceutical Association, the State Association of County Commissioners, the Florida Legal Service, and the Florida Association of Welfare Executives.

It is noteworthy and helpful to the people that state government has called upon all the groups involved in medical and health care delivery and financing to participate in planning and implementing the redevelopment of state law in response to the obvious deficiencies of health care of the poor in Florida.

Meeting regularly in Tallahassee, in anticipation of the 1978 Legislative Session, the committee has already issued a policy statement on Florida's Medicaid Program. The effort now is to produce a program acceptable to all the sectors of the health industry involved. It was recognized early that many of the difficulties with the Medicaid Program have come about from a lack of understanding among the various health care industries and the state government. This deficiency has resulted in an uncoordinated and inadequate program of health care for the poor.

Space limitations prohibit a full account here of all the redevelopment proposals under consideration by this unique and broadly representative committee. Suffice to say these endeavors address such current Medicaid Program problem areas as financing, budgeting and appropriations, payment program for providers and service delivery systems.

There seems little likelihood of new sources of state revenue being enacted into law this election year. New taxes are unlikely in an election year. Governor Askew has also declared that he will not recommend any new or additional state taxes in 1978. Since underfunding of Medicaid lies at the heart of many of the problems, this is the area addressed first.

The possibility of solving this dilemma may lie in the utilization of present tax revenues at the local governmental level — e.g., county and city taxes — now being expanded to provide medical and health care services to county and city residents

Dr. Papper is Vice President for Medical Affairs and Dean, University of Miami School of Medicine, Miami.

not currently eligible for any other insurance or welfare financial programs.

If the legislative vehicle can be developed to mobilize these dollars from each county with the present state Medicaid appropriation, a vastly larger Federal share of the total cost of the program will be generated. In an effort to develop this kind of a new state law and funding program, Steve Freedman, appointed by Secretary Page to direct the work of the redevelopment committee, and others have made numerous trips to HEW in both Atlanta and Washington, D.C.

The committee believes that this increase of Federal funds for the Florida Medicaid Program will be greater than the predicted increase in utilization. If the proposed changes are enacted by the state legislature this next Spring and additional Federal dollars begin to flow into the Program then, without increasing the State appropriation from general revenue sources, more Floridians will receive more Medicaid care — new funds will be able to provide adequate compensation for services rendered — and, a modest expansion in the kinds of services may be possible.

I hope that all physicians in Florida will take an active interest in and strongly support this cooperative effort to make Medicaid in Florida the successful program that it can be in the interests of serving the people better.

• Dr. Papper, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152.

Statement on Health Care For the Indigent

The following statement on health care for the indigent was approved by the FMA Board of Governors at its meeting on January 14, 1978:

Access *to medical care appropriate to their needs should be available to all regardless of socio-economic status.*

Guidance *may be needed by the indigent population to appropriately utilize available health care resources. Government and the medical profession should cooperatively seek the development of methods for the Medicaid Program to:*

A. Encourage the appropriate selection of primary care physicians or facilities.
B. Maintain stability in patient-physician relationship.
C. Foster education in preventive medical care, particularly in the ambulatory setting as opposed to institutional care.

Delivery *of health care for the indigent should be in the same setting, both ambulatory and institutional, as it is provided for the rest of the population in order to insure the quality, availability, and economy of health care for all residents.*

Administration *of the Florida Medicaid Program should be restructured to encourage the cooperation of staff and health care providers at the community level in planning, policy and delivery of health care and permit flexibility in the development of delivery and payment methods appropriate to a variety of community needs. There should be cooperation in terms of interrelation of forms that mesh smoothly with the on-going health care program.*

Funding *should be realistic, oriented toward ambulatory care and in accordance with acknowledged objectives with public accountability of expenditures delineating administrative costs and health service reimbursement.*

When it's pinworms, treat the family



Brief Summary of Prescribing Information

Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

RC/RD PD JA 1699-2-P (8-76)

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- two dosage forms: Tablets and Suspension—suitable for the entire family

Povan—there's a form for every member of the family.

PARKE-DAVIS

Our new Medical Necessity Program has two worthy goals:

(1) To help contain costs.
(2) To upgrade medical care.

This program initially identifies 28 surgical and diagnostic procedures which will not be paid routinely by Blue Shield. All pertinent claims will be reviewed for medical necessity and covered only when a clear need can be proven.

Following is a list identifying the 28 surgical and diagnostic procedures:

1. Ligation of Internal Mammary Arteries, Unilateral or Bilateral
2. Radical Hemorrhoidectomy, Whitehead Type
3. Omentopexy — Portal Obstruction
4. Kidney Decapsulation, Unilateral and Bilateral
5. Perirenal Insufflation
6. Nephropexy
7. Circumcision, Female
8. Hysterotomy
9. Supracervical Hysterectomy
10. Uterine Suspension
11. Uterine Suspension with Presacral Sympathectomy
12. Hypogastric or Presacral Neurectomy
13. Fascia Lata by Stripper — when used to treat lower back pain
14. Fascia Lata by Incision — when used to treat lower back pain
15. Ligation of Femoral Vein, Unilateral and Bilateral — when used to treat Post Phlebitic Syndrome
16. Excision of Carotid Body Tumor — when used to treat Asthma
17. Sympathectomy, Thoracolumbar, Unilateral or Bilateral — when used to treat Hypertension
18. Sympathectomy, Lumbar — when used to treat Hypertension
19. Basal Metabolic Rate — BMR
20. Protein Bound Iodine — PBI
21. Icterus Index
22. Ballistocardiogram — BCG
23. Phonocardiogram with Interpretation and Report
24. Angiocardiography, using Carbon Dioxide, Supervision and Interpretation Only
25. Angiocardiography, Single Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
26. Angiocardiography, Multi-Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
27. Angiography — Coronary, Unilateral, Selective Injection, Supervision and Interpretation Only, Single View unless in an Emergency
28. Angiography Extremity

This program was developed in cooperation with The American College of Physicians, The American College of Surgeons and The American College of Radiology. We ask your support in making our Medical Necessity Program 100% effective.*

*A claims review by The Florida Plan indicated that most of the procedures were already being screened for medical need and few of the services in question were being performed in Florida.



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MOUNT SINAI MEDICAL CENTER OF GREATER MIAMI
NATIONAL FOUNDATION FOR ILEITIS AND COLITIS
PROGRAM

"CONSULTATIONS IN CLINICAL GASTROENTEROLOGY"

FEBRUARY 28-MARCH 1, 1978

Tuesday morning, February 28 — Moderator: G. Gordon McHardy, M.D.

8:00 AM	Registration	Louis E. Wolfson Auditorium Lobby
8:30- 9:00	Antibiotics in Gastrointestinal Disease	K. Ratzan, M.D.
9:00- 9:30	Motility Disturbance of the Esophagus	C. Espiritu, M.D.
9:30-10:00	Ulcer Therapy: New and Old Tradition	G. McHardy, M.D.
10:00-10:15	Coffee Break	
10:15-10:45	Therapeutic Endoscopy	S. Kaplan, M.D.
10:45-11:15	Irritable Colon and Diverticular Disease	A. Rogers, M.D.
11:15-11:45	Panel Discussion: Drs. McHardy, Ratzan, Espiritu, Kaplan, Rogers	

Tuesday afternoon, February 28 — Moderator, Allan A. Kaplan, M.D.

1:30- 2:00	Drug-Induced Liver Disease	C. Espiritu, M.D.
2:00- 2:30	Spectrum of Chronic Hepatitis	E. Schiff, M.D.
2:30- 3:00	Acute Cholangitis	A. Kaplan, M.D.
3:00- 3:30	Cholestasis	E. Schiff, M.D.
3:30- 3:45	Questions and Answers	

Wednesday morning, March 1 — Moderator: Martin H. Kalser, M.D.

8:30- 9:00	The Medical Management of Ulcerative Colitis and Crohn's Disease. Results of the Long Term Trial of 6-Mercaptopurine Therapy	B. Korelitz, M.D.
9:00- 9:30	Systemic Manifestations of Chronic Inflammatory Bowel Disease	W. Ludwig, M.D.
9:30-10:00	Toxic Megacolon	F. Tedesco, M.D.
10:00-10:15	Coffee Break	
10:15-10:45	The Surgical Management of Ulcerative Colitis and Crohn's Disease with Considerations of Recurrent Ileitis	B. Korelitz, M.D.
10:45-11:15	The Continent Ileostomy	M. Goldsmith, M.D.
11:15-11:45	Panel Discussion: Drs. Kalser, Tedesco, Ludwig, Korelitz, Goldsmith	

Wednesday afternoon, March 1 — Moderator: Arvey I. Rogers, M.D.

1:30- 2:00	Update Pancreas	J. Barkin, M.D.
2:00- 2:30	Non-Invasive Techniques in Diagnosis of Pancreatic Disease	M. Viamonte, Jr., M.D.
2:30- 3:00	Surgical Treatment of Chronic Pancreatitis	F. Ackroyd, M.D.
3:00- 3:30	Diagnostic Approach to Malabsorption Syndrome	A. Rogers, M.D.
3:30- 4:00	Panel Discussion: Drs. Barkin, Ackroyd, Viamonte, Rogers	

Course Description:

This course is directed towards the practicing physician and surgeon in the specifics of diagnosis, treatment and practical application of the most recent advances in gastroenterology. Sufficient time will be allotted for the panel discussions and question and answer periods for the registrants to confer with the faculty.

CARMELITA R. ESPIRITU, M.D.
PROGRAM DIRECTOR

ACCREDITATION

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DIRECTOR OF MEDICAL EDUCATION

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* **INDICATIONS:** Based on a review af this preparatian by the National Academy of Sciences—Natianal Research Cauncil and/or ather infarmatian, FDA has classified the indications as fallaws: **Possibly effective:** In cutaneaus candidiasis; superficial bacterial infectians; the fallawing conditians when complicated by candidal and/or bacterial infectian: atopic, eczemataid, stasis, nummular, cantact, ar sebarrheic dermatitis, neurodermatitis, and dermatitis venenata; infantile eczema; lichen simplex chranicus; and pruritus ani and pruritus vulvae.

Final classificatian af the less-than-effective indicatians requires further investigatian.

CONTRAINDICATIONS: Viral diseases af the skin (such as vaccinia and varicella); fungal lesions af the skin except candidiasis; history af hypersensitivity to any praduct campanent. Nat intended far aphthalmic use; shauld nat be applied in the external auditary canal af patients with perfarated eardrums; shauld nat be used when circulatian is markedly impaired.

WARNINGS: Because af the patential hazard af nephrataxicity and atataxicity, prolanged use ar use of large amounts af this praduct shauld be avaided in the treatment af skin infectians fallawing extensive burns, traphic ulceratian, and ather canditians where absorptian af neomycin is passible.

Usage in Pregnancy: Although tapical steraids have nat been reparted ta have an adverse effect an the fetus, the safety af tapical steraids during pregnancy has nat been absalutely establishec therefare, da nat use extensively an pregnant patients, in larg amaunts, ar far pralanged periods.

PRECAUTIONS: Watch canstantly far avergrawth af nansusceptibl arganisms (including fungi ather than candida). Shauld superinfec tian due ta nansusceptible arganisms accur, administer suitabl cancamitant antimicrabial therapy; if favarable respanse is nat pramp discantinue the preparatian until adequate cantral by ather ant infectives is effected. If extensive areas are treated ar if the acclusiv technique is used, the passibility exists af increased systemic absarp tian af the carticasteraid; suitable precautians shauld be taken. irritatian develops, discantinue the praduct and institute appropriat therapy.

ADVERSE REACTIONS: Sensitivity reactians ta tapical use af gramicidi are rare. Hypersensitivity ta nystatin is extremely uncamman. Hype sensitivity ta neamycin has been reparted and articles in the currer medical literature indicate an increase in its prevalence.

The fallawing lacal adverse reactians have been reparted wit tapical carticasteraids either with ar withaut acclusive dressings: burr ing sensatians, itching, irritatian, dryness, fallicultis, secandary infec tian, skin atraphy, striae, miliaria, hypertrichasis, acnefarm eruptian maceratian af the skin, and hypapigmentatian. Cantact sensitivity to particular dressing material ar adhesive may accur accasianally. Otc taxicity and nephrotaxicity have been reparted.

For full prescribing infarmatian, cansult package insert.

HOW SUPPLIED: Available in 15, 30, and 60 g. tubes. It is also avai able in jars of 120 g. (4 oz.) far haspital ar institutianal use anly.

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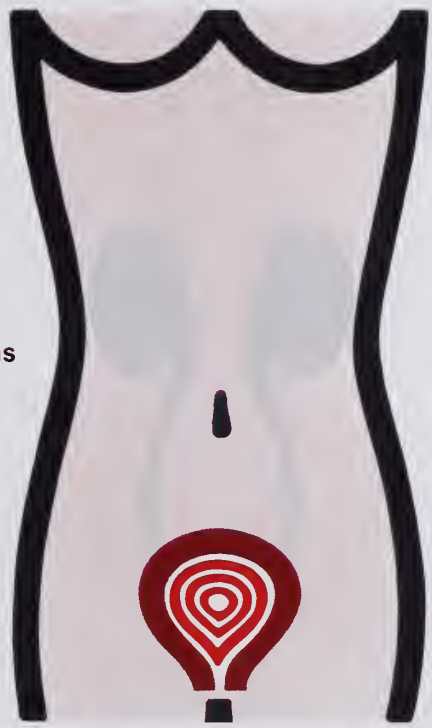
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When pain complicates acute cystitis*

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl

for the pain for the pathogens



□ **Early relief of painful symptoms** such as burning and pain associated with urgency and frequency.

□ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

□ **Appropriate antibacterial therapy:** up to three days therapy with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole), 0.5 Gm tablets.

*Nonobstructed; due to susceptible organisms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: **Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

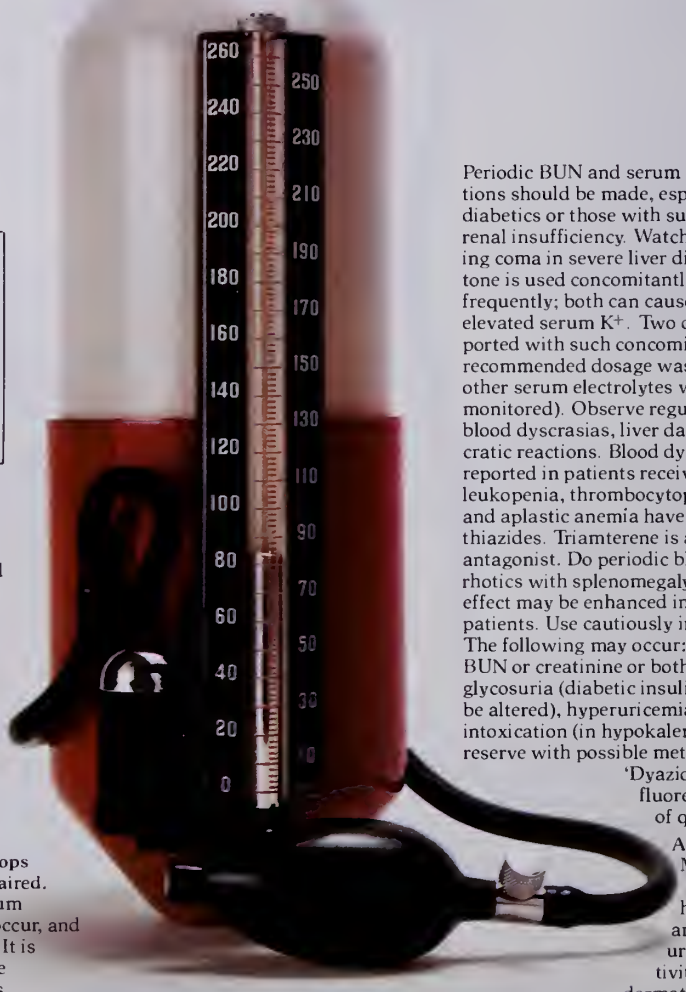
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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

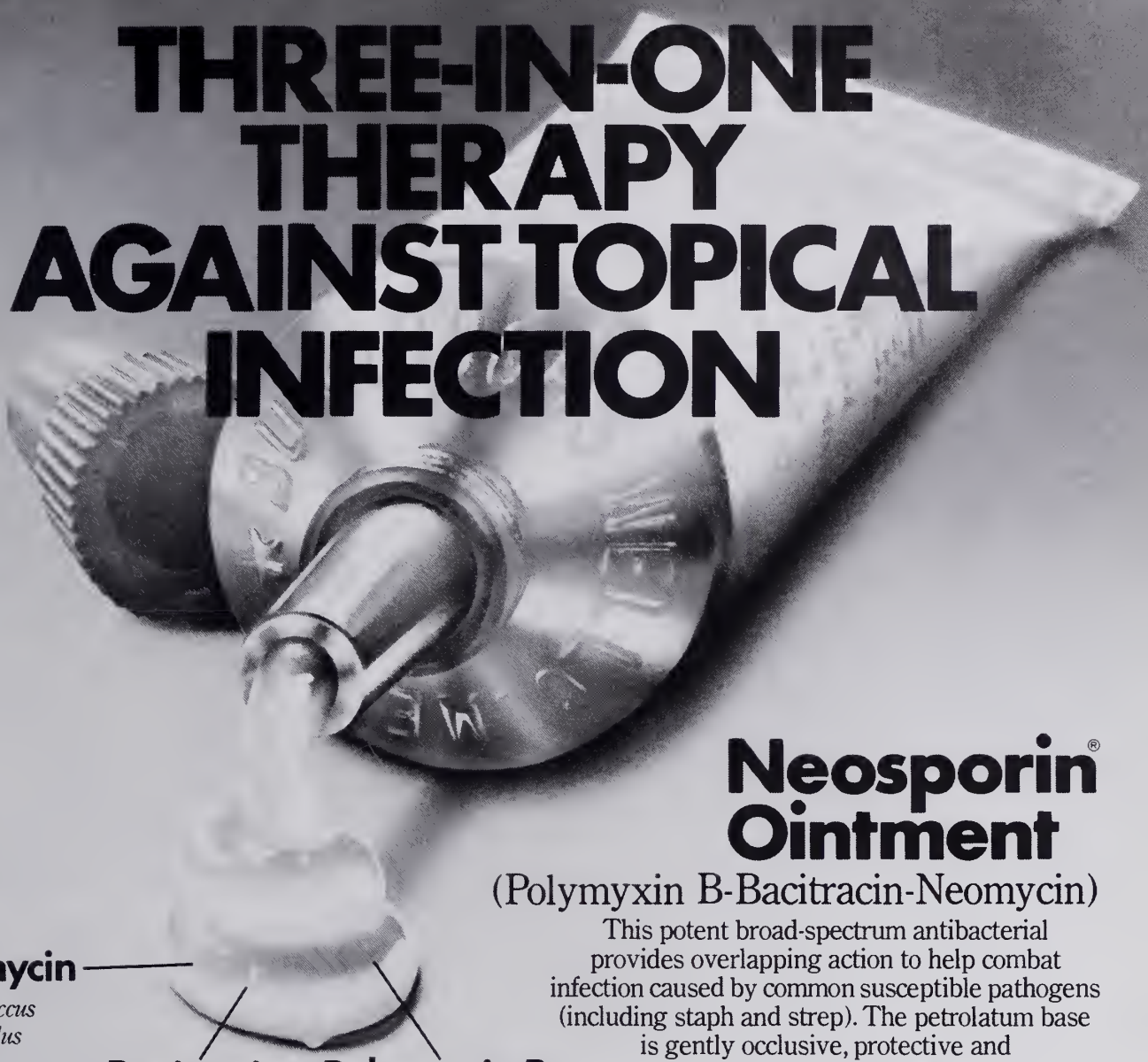
Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

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In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

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Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

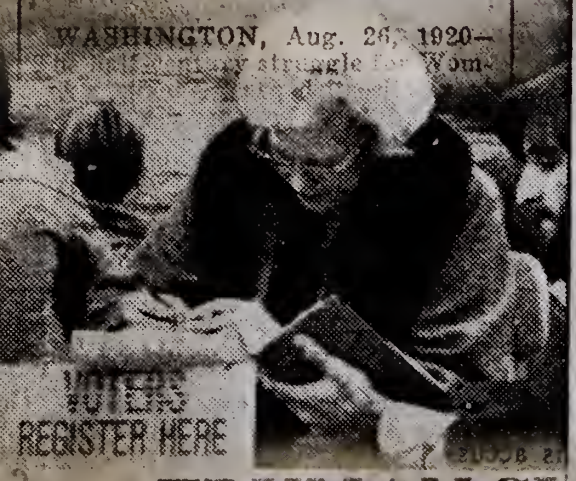
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,00 Persons When States Adopt Cooperating Laws–He C the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14 The Social Security Bill, pr a broad program of unempl insurance and old age pe and counted upon to bene 20,000,000 persons, became day when it was signed b dent Roosevelt in the pre those chiefly responsible f ting it through Congre s.

Mr. Roosevelt calle the m "the corrnerstone in a s which is being b m s s ple

co

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

TRUMAN CLOSES ITED NATIONS CONFEREN VITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

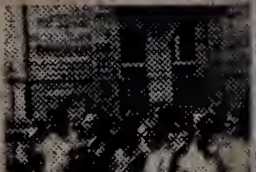
"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the eight United States delegates to

SAN FRANCISCO, June 26, 1945

SIGNI the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005



FROM THE EDITOR'S DESK

KELLOGG GRANT

The National Joint Practice Commission has received a grant to study guidelines for establishing joint physician-nurse practice in hospitals. The grant, for $765,765, was awarded by the W. K. Kellogg Foundation. The AMA Education and Research Foundation will administer the funds. The Joint Practice Commission was formed five years ago by the AMA and the American Nurses' Association.

* * * *

COURT DECISION

The AMA position that physicians employed by hospitals are entitled to the same rights as other physicians has been upheld by a federal court of appeals. Quentin Young, M.D., a frequent critic of AMA in previous years, commended the organization for doing a "bold thing by lending its support." Dr. Young had been fired without notice or hearing from his job as director of the Department of Medicine at Chicago's Cook County Hospital on charges he encouraged a strike by housestaff. AMA contributed $15,000 toward his legal expenses on the ground that physicians in hospital administrative positions with clinical responsibilities are entitled to the same hearing and procedural rights as physicians on the voluntary hospital staff.

* * * *

QUALITY OF LIFE

AMA's Fourth Quality of Life Conference will be held next April 17-19 at the Conrad Hilton Hotel in Chicago. Television personality Hugh Downs will keynote the meeting as he has the three previous congresses.

TRANSFER STUDENTS

At least eight U.S. medical schools have announced they will not waive regular admissions requirements to accommodate Americans transferring back from foreign medical schools. They are Johns Hopkins, Harvard, Indiana, Sanford, St. Louis, UCLA, Wright State, and Yale. The Health Professions Educational Assistance Act requires schools to reserve places in their third-year classes for these students or lose their capitation grants. Consideration of students' academic qualifications is not allowed. Meanwhile, Congress has under consideration HR 8519 that would replace the Assistance Act. It would require medical schools, as a condition for capitation grants, to increase their third-year class enrollment for each academic year beginning next fall.

* * * *

ACCREDITED JAILS

The AMA has accredited medical programs in 16 jails and prisons participating in its Program to Improve Medical Care and Health Services in Jails. New or revised health care standards had been initiated in jails in the six pilot states of Georgia, Indiana, Michigan, Maryland, Wisconsin and Washington. The Jail Project is operating in its second year of a three-year grant from the federal Law Enforcement Assistance Administration.

* * * *

BIRTH/DEATH RATES

Both birth and death rates dropped in the United States last year. The birth rate was 14.7 per 1,000 population, compared with 14.9 the previous year. Last year 8.9 people per 1,000 population died, a figure virtually unchanged from 1975, but down from 1974's 9.2.

COST CONTAINMENT

The AMA and two other organizations are developing a voluntary hospital cost containment program. Joining with AMA in the program are the American Hospital Association and the Federation of American Hospitals. A national steering committee consisting of hospital people, doctors, insurers, consumers and others is being formed. It will develop goals and mechanisms of a voluntary program to reduce the rate of increase in hospital costs and the rate of increase in health costs as a whole. The three organizations acted in response to a challenge by Rep. Dan Rostenkowski, Chairman of the House Ways and Means Subcommittee on Health.

* * * *

MEDICAID WASTE

HEW Secretary Joseph Califano says more than $2 billion a year in Medicaid funds is wasted because of welfare agency mismanagement and not because of provider abuse. During fiscal 1977, according to Califano, at least $1.2 billion was paid for services to persons who were ineligible, while $200 million was lost through duplicate payments, overpayments and payments to ineligible providers. Another $600 million was lost through government failure to collect from third party payers and worker compensation funds.

* * * *

CAPITATION REFUSED

Three Chicago area medical schools—University of Chicago, Northwestern and the University of Illinois Medical Center—say they will refuse federal capitation grants rather than accept U. S. transfer students from foreign medical schools. The federal health manpower bill requires schools receiving capitation to accept a proportional number of these students regardless of academic standing and qualifications.

* * * *

COSTLY REGULATIONS

The Michigan Hospital Association has found it costs hospitals about $36 per inpatient stay just to comply with government regulations. The cost figure arose from a survey of six hospitals that covered such regulations as utilization and PSRO reviews, plant codes, personal management, the state's arbitration program, certificate of need requirements, and federal reimbursement mechanisms.

CME ACCREDITATION

As of October 21, 1,464 institutions and organizations had been accredited in the United States for continuing medical education. They include 114 medical schools, 347 national, state and local specialty societies, 33 voluntary health agencies, 32 state medical associations, 781 hospitals, and 157 others.

* * * *

SURVEY

The National Opinion Research Center in New York City has been engaged by the Social Security Administration to conduct a study of the cost of running a medical practice. About 12,000 physicians are to be contacted by telephone. The AMA has neither authorized nor endorsed the survey.

* * * *

HELPING HAND

The AMA has offered members of Congress its assistance in responding to constituent inquiries on health or medical problems. AMA is making available to congressmen separate pamphlets on cancer, smoking and blood pressure, in bulk quantities.

* * * *

TAX BREAK

President Carter was expected to sign into law a bill to give 10,000 medical students a tax break. Congress voted a two-year exemption from taxation on federal scholarship stipends under the Armed Services Health Professions Scholarships and the Public Health Service National Health Service Corps scholarship program. AMA proposed legislation to make the exemption permanent.

* * * *

CME NEWSLETTER

The American Medical Association's "Continuing Medical Education Newsletter" has made its reappearance after an absence of three years. The revived publication is being edited by Dr. Marvin E. Johnson, Director of the Department of Physicians Credentials and Qualifications.

DRAFT LEGISLATION

The AMA Board of Trustees has approved four pieces of draft legislation. One bill would require Medicare reimbursement in a new practice at levels generally recognized in the area, rather than limiting reimbursement to the 50th percentile. Other proposals would allow physicians the same billing options under Medicaid as under Medicare; require new federal facilities (except military) or health services to meet all state, federal and local Title XV planning requirements; delete a provision in the Public Health Service Act that singles out physicians and dentists as the first group for which data would be collected on health professionals and restrict the data to that which would not identify an individual practitioner.

* * * *

AMA-ERF

AMA members have been sent letters asking them to support three major programs of the AMA Education and Research Foundation. They include the AMA Loan Guarantee Fund, the Medical School Fund and the Unrestricted Fund. The programs provide funding for medical students, medical schools, research, health education, experimental programs of care and other worthy activities.

* * * *

AD INCOME UP

A significant increase has been noted in the advertising revenues of journals published by the AMA. Total revenue reached $10 million through October in fiscal year 1977, a 19% increase over the same period of last year. **JAMA** was up 18%, specialty journals 27%, and **American Medical News** 22%.

* * * *

AMA SATISFIED

AMA says the Department of HEW's corrected list of physicians whose Medicare billings exceeded $100,000 fairly reports all errors cited by physicians named on the original list last spring. But AMA expressed disappointment that HEW did not contact all solo practitioners, groups and laboratories listed in the original release. HEW staffers contacted only those who filed complaints about their original listings through AMA, local Medicare carriers, or regional HEW offices.

* * * *

COST CURBING

The U. S. Chamber of Commerce has called upon business and industrial leaders to help curb health care costs by joining health systems agencies, serving on hospital boards, and promoting alternative delivery systems such as Health Maintenance Organizations. But in an October newsletter, the Chamber said its affiliate foundation is expected to recommend a national health care strategy that stresses private initiatives rather than more government regulations.

* * * *

PUBLIC RELATIONS

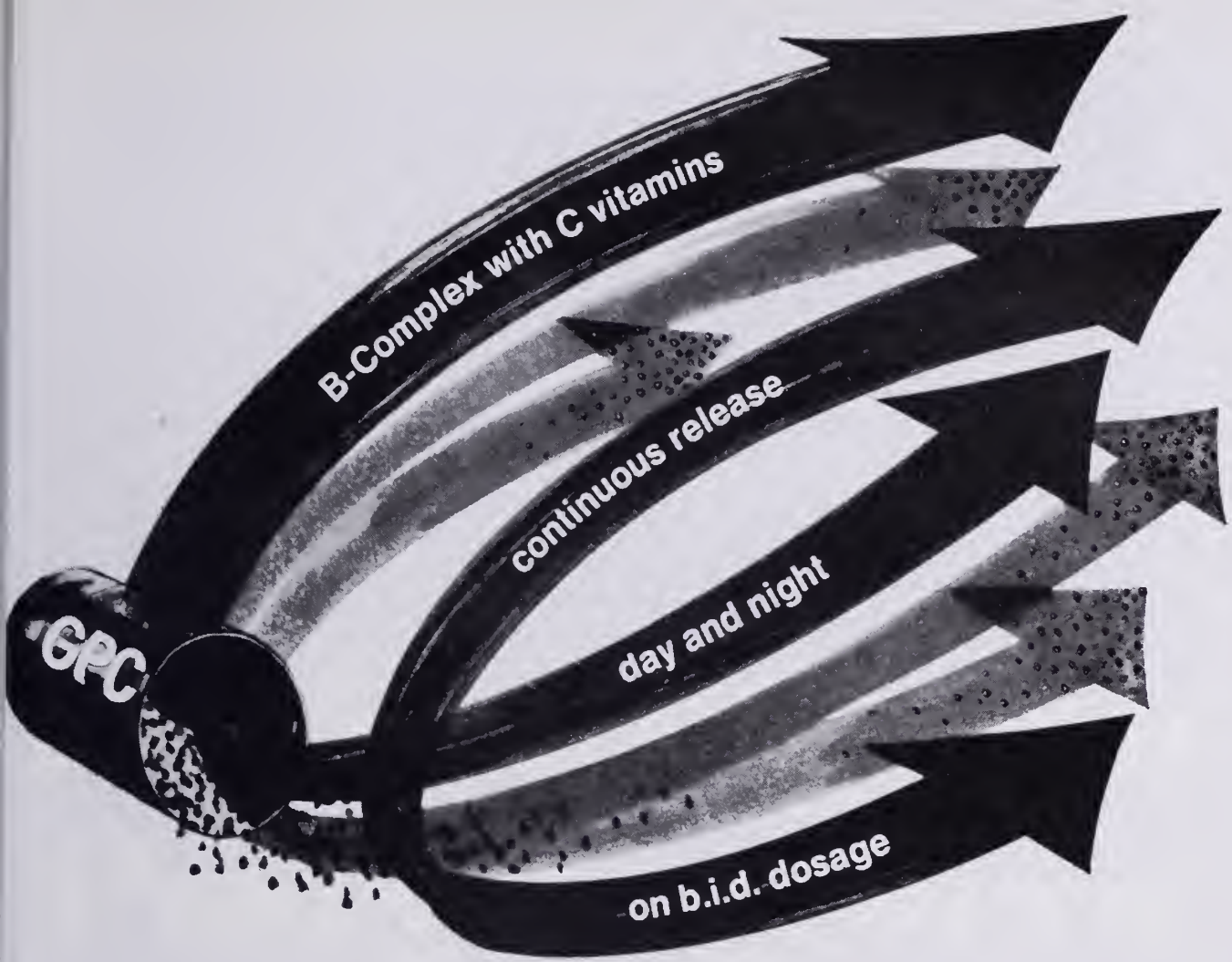
A Chicago-based advertising agency is developing for the American Medical Association an informational advertising campaign that emphasizes the positive aspects of American medicine. Ads will appear in five national publications. Other aspects of the program will include implementing national PR priorities at the local level, and utilizing medical spokesmen on television and before non-medical audiences.

* * * *

GALLUP SURVEY

A recent Gallup survey indicates that most Americans rate the quality of their health care as high. But the public believes that older people and people living in rural areas get inferior care. Public support for national health insurance varies in relation to public understanding of how much such a program would cost. About 67% believe there is a need for national health insurance, but this percentage drops to 40% when the question is expanded to include additional taxes to finance such a program.

The Editor



introducing B-C-BID

B-complex with C

an improved delivery system sustained release by micro-dialysis diffusion

New B-C-BID provides a smooth, continuous, predictable rate of release of water-soluble B complex and C vitamins. Your patient can now *retain more* of these vitamins because higher tissue levels can be sustained much longer than is possible with ordinary formulations.

Wherever B complex with C is indicated . . . prescribe the product that delivers most efficiently . . . new B-C-BID.



EACH B-C-BID CAPSULE CONTAINS:

Vitamin B-1 (Thiamine Mononitrate)	15 mg
Vitamin B-2 (Riboflavin)	10 mg
Vitamin B-6 (Pyridoxine)	5 mg
Niacinamide	50 mg
Calcium Pantothenate	10 mg
Vitamin C (Ascorbic Acid)	300 mg
Vitamin B-12 (Cyanocobalamin)	5 mcg

DOSAGE: *FOR CONTINUOUS 24 HOUR THERAPY, ONE CAPSULE AFTER BREAKFAST AND ONE AFTER SUPPER.* SAMPLES ON REQUEST.

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This 113-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

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According to recent surveys by two leading pharmaceutical journals, Purepac is the number one generic most preferred by pharmacists in the United States. Yet, it's quite possible you've never even heard of us. Simply because Purepac has no detail men.

That's good news and bad news.

Good news because we pass on all those savings in salaries directly to your patients through lower prices to pharmacists.

Bad news because we're unable to personally tell you about Purepac's quality control and new drug applications. Or that our bioequivalence is every bit as good as the more expensive national brands.

Matter of fact, Purepac generics are equivalent to all brand names in every respect, except for one... PUREPAC COSTS LESS.

So while it's true we could use the extra recognition a staff of detail men could give us, perhaps the reverse is also true. That we can get a lot more recognition by passing the savings on to your patients in every Purepac prescription.

See the Purepac listing in the white pages of the 1978 PDR.

PUREPAC

Elizabeth, NJ 07207

AMERICA'S LEADING NATIONAL BRAND OF GENERICS



Enrique M. deArrigoitia, M.D., of Winter Park . . . has been installed as President of the Central Florida Society of Dermatology. Other new officers chosen at the Society's December meeting are: Jose V. Lara, M.D., Winter Park, Vice President and President-elect; and Charles R. Noble, M.D., Orlando, Treasurer.

Thad M. Moseley, M.D., of Jacksonville . . . will preside at the 46th annual assembly of the Southeastern Surgical Congress in New Orleans, February 19-22.

About 2,000 surgeons, surgical nurses and medical and nursing students from 13 states, the District of Columbia and Puerto Rico are expected to attend.

Dr. Moseley, a former Editor of **The Journal of the Florida Medical Association,** will be succeeded as President by C. Melvin Bernhard, M.D., of Louisville, Ky.

Robert W. Bright, M.D., of Gainesville . . . has been named a recipient of the 1978 Kappa Delta Award of the American Academy of Orthopaedic Surgeons.

Philip D. Wilson, Jr., M.D., of New York, Chairman of the Academy's Advisory Committee on Research, said Dr. Bright was honored for a paper on "Surgical Correction of Partial Growth Plate Closure, Laboratory and Clinical Experience."

Dr. Bright, Associate Professor of Orthopedic Surgery and Pediatrics at the University of Florida College of Medicine, will present the paper at the combined meeting of the American Academy of Orthopaedic Surgeons and the Orthopedic Research Society in Dallas.

Specialty board certification . . . will be accepted as full compliance with the Florida Medical Association's mandatory continuing medical education program for members.

The Committee on Continuing Medical Education and the Council on Scientific Activities have voted to accept certification or recertification by any of the 22 approved boards as fulfillment of the requirements for one three-year reporting cycle.

Physicians certified by the American Board of Internal Medicine in medicine or a subspecialty on January 1, 1975 or after may report certification. Orthopedic surgeons certified by their Board on or after January 1, 1976 may do likewise.

The CME Committee subsequently adopted a new policy with regard to board certification and accepted the remaining 20 boards effective as of January 1, 1977.

These are the Boards of: Allergy and Immunology, Anesthesiology, Colon and Rectal Surgery, Dermatology, Family Practice, Neurological Surgery, Nuclear Medicine, Obstetrics and Gynecology, Ophthalmology, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, Preventive Medicine, Psychiatry and Neurology, Radiology, Surgery, Thoracic Surgery, and Urology.

Certification or recertification in a primary specialty, subspecialty or area of special competence will be acceptable.

Mercy Hospital in Miami . . . has been accredited for continuing medical education by the Liaison Committee on Continuing Medical Education.

LCCME, at its meeting in December, granted one-year provisional accreditation on the recommendation of the FMA Committee on Continuing Medical Education, which had conducted an onsite survey of the facility.

In another action, LCCME reaccredited for three years the CME program of the Sarasota County Medical Society.



Simple drops of water help make COLACE® the most widely used stool softener.

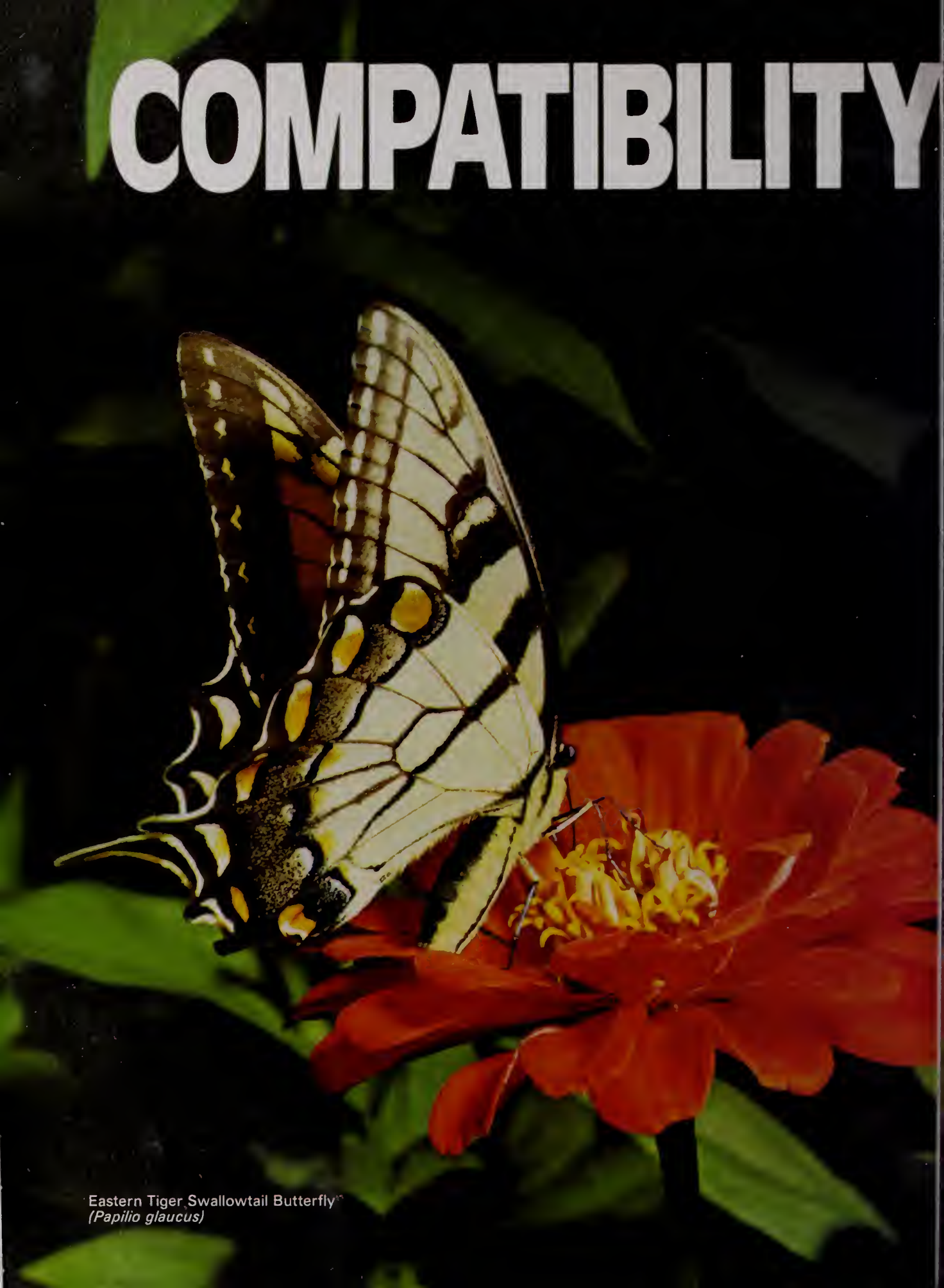
COLACE®
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COLACE works by stool-softening action alone, free from laxative stimulation. Simply by letting natural intestinal water permeate stools, COLACE helps to eliminate the hard, dry stools common to constipation.

COLACE works to prevent pain and straining at stool with minimum chance of griping or cramps, particularly in patients with delicate anorectal disorders. COLACE is safe and non-habit forming in short- or long-term therapy. COLACE—the simple water way to ease constipation from infancy to old age. Capsules, syrup or liquid.

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COMPATIBILITY



Eastern Tiger Swallowtail Butterfly
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Does it influence your choice of a peripheral/cerebral vasodilator*?

Vasodilan–compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

Vasodilan–compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

Vasodilan–compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:
Possibly Effective:
1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.
Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.
Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.
Parenteral administration is not recommended in the presence of hypotension or tachycardia.
Intravenous administration should not be given because of increased likelihood of side effects.
Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.
Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.
Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.
Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836



VASODILAN® 20-mg tablets

(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

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Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- high theophylline for effective around-the-clock therapy
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Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.

Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.

Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

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THE FLORIDA MEDICAL ASSOCIATION INC
FEBRUARY 1978 • VOL. 65 • NO. 2

An Overview of Surgical Intervention for Obesity

J. P. O'Leary, M.D.; J. B. Weeks, M.D., and E. R. Woodward, M.D.

Abstract: We believe that jejunoileal bypass surgery for morbid obesity is a procedure that is still in its developmental phases. It should be reserved for those patients with complications of obesity which place them at an increased risk for survival. It should only be done by clinicians who have an ongoing interest in obesity and who have a commitment for long-term follow-up. The long-term effect on survival is not known. In this series, the beneficial effect of the bypass and its concomitant weight loss was demonstrated in the associated diabetes mellitus, hypertriglyceridemia, hypercholesterolemia, congestive heart failure, the Pickwickian syndrome, and stasis ulcers of the lower extremity. The beneficial effect seen on hypertension was less dramatic, although one third of the patients appeared improved.

Obesity has become a major health hazard not only in this country but around the world. The disease has reached epidemic proportions in the United States with approximately 25%-45% of the adult population being 20% or more overweight.[1] It has been estimated that greater than 15% of children weigh more than 40% above their projected ideal weight.[2] In adulthood the morbidity and mortality associated with this disease becomes significant. Obesity predisposes to hyperlipidemia and hypertension,[3] all of which are risk factors for coronary artery disease. Additional problems that are associated with the obese state include cerebral thrombosis, glucose intolerance, cholelithiasis, degenerative arthritis, venous stasis of the lower extremity, and infertility.

Diets have become very popular but produce maintained weight loss in less than 5% of cases. Although jejunoileal bypass must be construed as a drastic measure, for some morbidly obese patients it may be the only way to produce sustained weight loss.

From the Department of Surgery, University of Florida College of Medicine, Gainesville.
This paper was presented by Dr. Woodward at the Florida Medical Association's Annual Meeting in Miami Beach, April 1975.
This work was supported in part by NIH Grant #AM04178.

To determine if intestinal bypass was effective in the treatment of the complications of morbid obesity, a prospective study was undertaken. All patients included in the group were extensively studied preoperatively and objective documentation of complications was obtained. Greater than 98% of these patients were re-evaluated in the postoperative period and documentation of improvement was recorded, if it had occurred.

Methods and Materials

From 1967 to early 1977, 200 patients underwent jejunoileal bypass at the University of Florida (Table 1). Criteria for selection of patients into the study group were stringent and have been previously reported.[4] All patients weighed in excess of 100 pounds over their projected ideal weight for more than seven years. All patients had previously been tried on extensive medical management without sustained weight loss. Each patient had a complication of obesity. These complications included diabetes mellitus, hypertriglyceridemia, hypercholesterolemia, hypertension, congestive heart failure, Pickwickian syndrome, stasis ulcers of lower extremity, and degenerative arthritis (Table 2).

The preoperative medical evaluation included a complete blood count with hemogram and indices, serum electrolytes, cholesterol, lipoprotein electrophoresis, carotene, vitamin A, vitamin B-12, folate, and liver function tests. The clearance of sulfobromophalein sodium by the liver was tested. Both intravenous and oral glucose tolerance tests were performed. Arterial blood gases were drawn on most patients. Routine studies obtained included a liver-spleen scan and oral cholecystogram. Where indicated, an upper gastrointestinal x-ray and an intra-

Table 1. — Demographic Data.

Number patients	200
Males	23%
Females	77%
Average age	34 years
Age range	9 - 59 years
Following-up range	6 months - 10 years

Table 2. — Medical Complication of Morbid Obesity.

Diabetes mellitus*	70%
Diabetes mellitus (insulin dependent)	6%
Hypertriglyceridemia	51%
Hypercholesterolemia	8%
Hypertension	46%
Congestive heart failure	10%
Pickwickian syndrome	11%
Stasis ulcers — lower extremity	17%

*Criteria established by Fajans and Conn.[6]

venous pyelogram were obtained. Endocrine studies were ordered when appropriate. At the time of operation, all patients had a liver biopsy.

The majority (190/200) had a procedure in which the jejunum, approximately 12 inches from the ligament of Treitz, was anastomosed in an end-to-side fashion to the terminal ileum, 4 inches proximal to the ileocecal valve (Fig. 1). The ten patients who did not have this type shunt had an end-to-end shunt utilizing similar measurements. This short-circuiting of the intestine produced a malabsorptive state and weight loss ensued.

Beneficial Effect of Jejunoileal Bypass

Weight: All patients in this series were at least 100 pounds over their ideal weight, with the majority ranging between 200%-300% of ideal. The mean preoperative weight was 345 pounds (Table 3). In the postoperative period, weight loss was rapid initially, gradually plateauing 12 to 36 months postoperatively. The average patient lost approximately one third of his preoperative body weight. The heavier a patient was, the greater the percent of weight loss. Although weight stabilization frequently occurred above a patient's projected ideal weight, most patients were improved with regard to their exercise tolerance and social acceptability. Approximately 80% of the patients were able to return to gainful employment postoperatively.

Glucose Intolerance: Seventy percent of patients in this series were diabetic by the criteria established by Fajans and Conn[5] for oral glucose tolerance testing. Where IV glucose tolerance was accomplished, better than 90% showed evidence of glucose intolerance as demonstrated by glucose decay curves. Because of the malabsorptive state produced in the postoperative period, oral glucose challenges performed at these times are difficult to interpret. However, at the time of the one year evaluation, only 113 of 119 patients tested (11%) were diabetic. In addition, all 12 patients who were on insulin at the time of their bypass were now completely off all hypoglycemic medications (Table 3). The mechanism whereby this apparent improvement in glucose metabolism has occurred is unclear at the present time.

Hyperlipidemia: Preoperatively, 8% of patients had hypercholesterolemia and 51% hypertriglyceridemia. All patients in the former group and 88% of those in the latter have had their serum lipid studies return to normal within the first six months after the procedure (Table 3).

Hypertension: Preoperatively, 46% of our patients had diastolic pressures $\geq$ 90 mm Hg. as measured with a thigh cuff on the arm. It should be noted that the use of a standard cuff on an obese extremity gives falsely elevated blood pressure readings. In the postoperative period, approximately one third of our patients have not required any antihypertensive medications (Table 3). One third seemed to require less medications, but one third are not improved. No parameters have been uncovered to predict which patients will be responders and which will be the nonresponders.

Congestive Heart Failure: Ten percent of patients demonstrated significant evidence of conges-

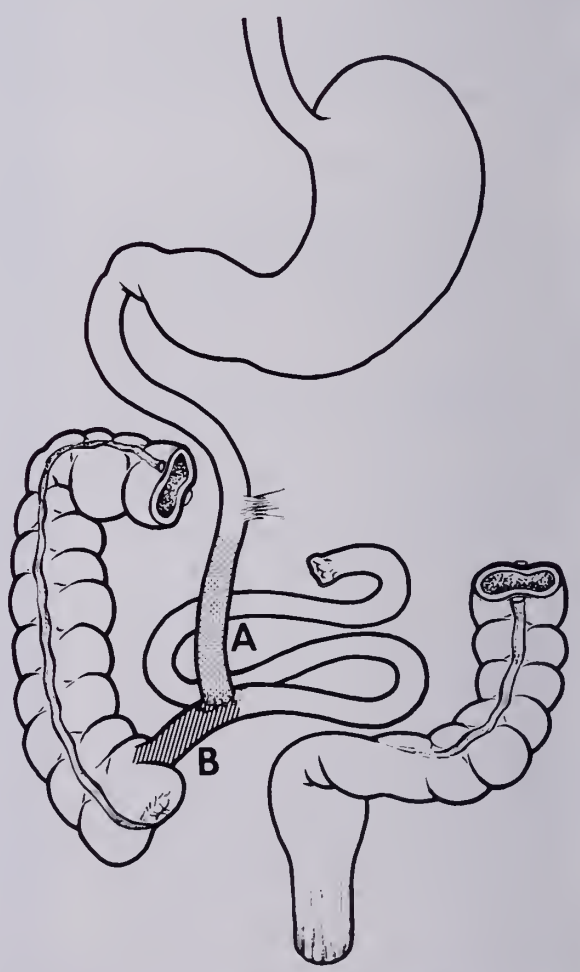


Fig. 1. — Schematic representation of operative procedure.

Table 3. — Beneficial Effect of Jejunoileal Bypass.

	Improved	Unchanged
Diabetes mellitus (insulin dependent)	100%	—
Hypertriglyceridemia	88%	12%
Hypercholesterolemia	100%	—
Hypertension	33%	66%
Congestive heart failure	90%	10%
Pickwickian syndrome	100%	—
Stasis ulcers — lower extremity	100%	—
Diabetes mellitus	89%*	11%

*70% (136/196) of patients had an abnormal oral glucose tolerance test preoperatively, while 11% (13/119) had an abnormal test postoperatively.

tive heart failure preoperatively. The majority of these patients were on digitalis. In the postoperative period, all these patients have improved subjectively, but one has continued to require digitalis (Table 3).

Pickwickian Syndrome: Eleven percent of patients have presented with symptoms classic for the Pickwickian syndrome. Although some of these patients may be suffering from sleep deprivation, all have demonstrated remarkable improvement in the postoperative period. Usually by the time the patient has lost 15-20 pounds the symptoms of somnolence in the sitting position have abated (Table 3).

Stasis Ulcers of Lower Extremity: Seventeen percent of patients have presented with massive stasis with ulceration of the lower extremity. Many have had previous operations to skin graft or make flaps in these areas. Most of these ulcers have healed within six weeks of the operation (Table 3). These changes may not be totally secondary to weight loss as during a substantial portion of this time patients' activity is curtailed and they may not be in the upright position for such prolonged periods. Only one ulcer has recurred during follow-up that extends up to six years.

Complications Following Jejunoileal Bypass

Although the main thrust of this paper is to point out the beneficial effect of jejunoileal bypass, the operation has many known complications.

Although diarrhea can be expected after this procedure, it can usually be controlled with diet modification, diphenoxylate hydrochloride with atropine sulfate, and oral calcium therapy. Mild hypocalcemia and hypomagnesemia are common, but usually inconsequential. If symptoms develop, oral elemental supplementation can be provided.

Oxalate nephrolithiasis was first reported as a complication of obesity bypass in 1973.[6,7] Fifteen percent of our patients have had at least one episode of postoperative urinary lithiasis. One patient has required takedown of his bypass secondary to recurrent nephrolithiasis.

Hepatic disturbances have been widely reported.[8-11] The usual preoperative hepatic steatosis progresses during the first postoperative year and then, in many patients, gradually returns toward normal. Some patients develop progressive liver failure with cirrhosis and subsequent death if bowel continuity is not restored. Forty five percent of our patients have developed significant abnormalities of their liver function studies in the postoperative period. These abnormalities are frequently accompanied by a clinical picture characterized by anorexia, nausea and vomiting. Four patients have required takedown of their jejunoileal bypass because of liver dysfunction. One patient died with a syndrome whose symptoms were compatible with liver failure, but permission for autopsy was denied. The etiology of this complication remains obscure, but probably involves not only malabsorption with subsequent malnourishment, but may also be associated with a toxic substance released from the bypassed limb of intestine. Although speculation is rampant, conclusive proof is lacking to support either of these theories to the exclusion of the other.

The 30-day operative mortality in our series was three percent. There have been four late deaths; one from pancreatitis, one from cancer, one from cardiac arrhythmia, and one from unknown causes suspicious of hepatic insufficiency as detailed above.

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Myelotomy in the Treatment of Spasticity

Laurance J. Guido, M.D.

Abstract: A neurosurgical method for the control of spasticity is presented. Four patients are described whose clinical states were significantly improved by a longitudinal myelotomy. A brief review of the therapy of spasticity is included. It is suggested that the myelotomy is a useful form of treatment in advanced spasticity.

The management of spasticity continues to be a frustrating problem. This communication describes an established, yet little used, neurosurgical procedure which effectively reduces spasticity. It is designed to reduce the inflow of peripheral impulses into the spinal cord which excite the motor neurons no longer inhibited by higher centers.

In 1951 Bischof described a new procedure in the treatment of flexor spasms that utilizes the "final common pathway."[1] The procedure involves a laminectomy from T10-12 and a longitudinal division of the spinal cord into an anterior and posterior half from T12 to S1 with an option of an extension to S5 (Fig. 1). The incision, in the horizontal plane, avoids all long tracts, yet interrupts both the mono- and polysynaptic reflex arcs. It is the aim of this operation to relieve spasticity and flexor spasms, while preserving some bladder function, touch and vibration senses. After opening the dura mater, the lumbar and sacral segments of the spinal cord should be appropriately identified with a nerve stimulator. Hemorrhage during the procedure is a minor problem and easily controllable.

This operation is not suitable for use in patients who retain residual motor or bladder function, for these can be lost after horizontal cord section. To avoid this complication, Bischof later advocated the dorsal longitudinal myelotomy (Bischof II procedure, Fig. 2).[2] The cord is incised in the midline from T11-S1. The knife is directed laterally through this incision to sever the reflex anastomoses bilaterally. An important feature of this myelotomy is the division of the collaterals of Kolliker. This eliminates the influx of afferent impulses from higher and lower segments, suggested as a cause of failure in some other procedures.[3,4]

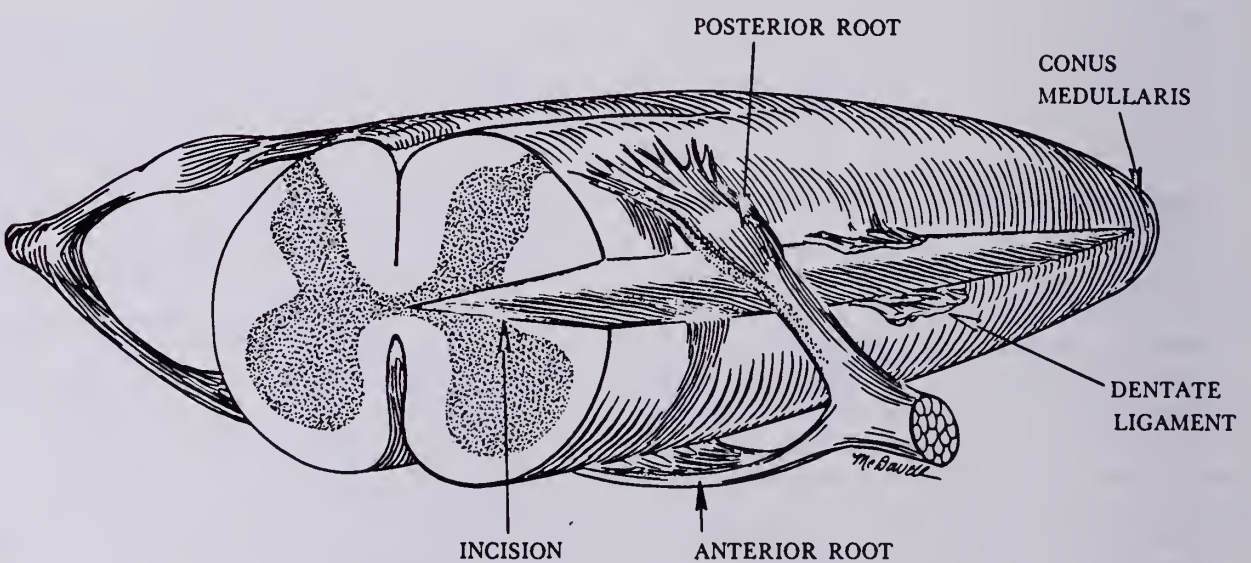


Fig. 1. — Demonstrating the initial Bischof procedure; horizontal section of the cord.

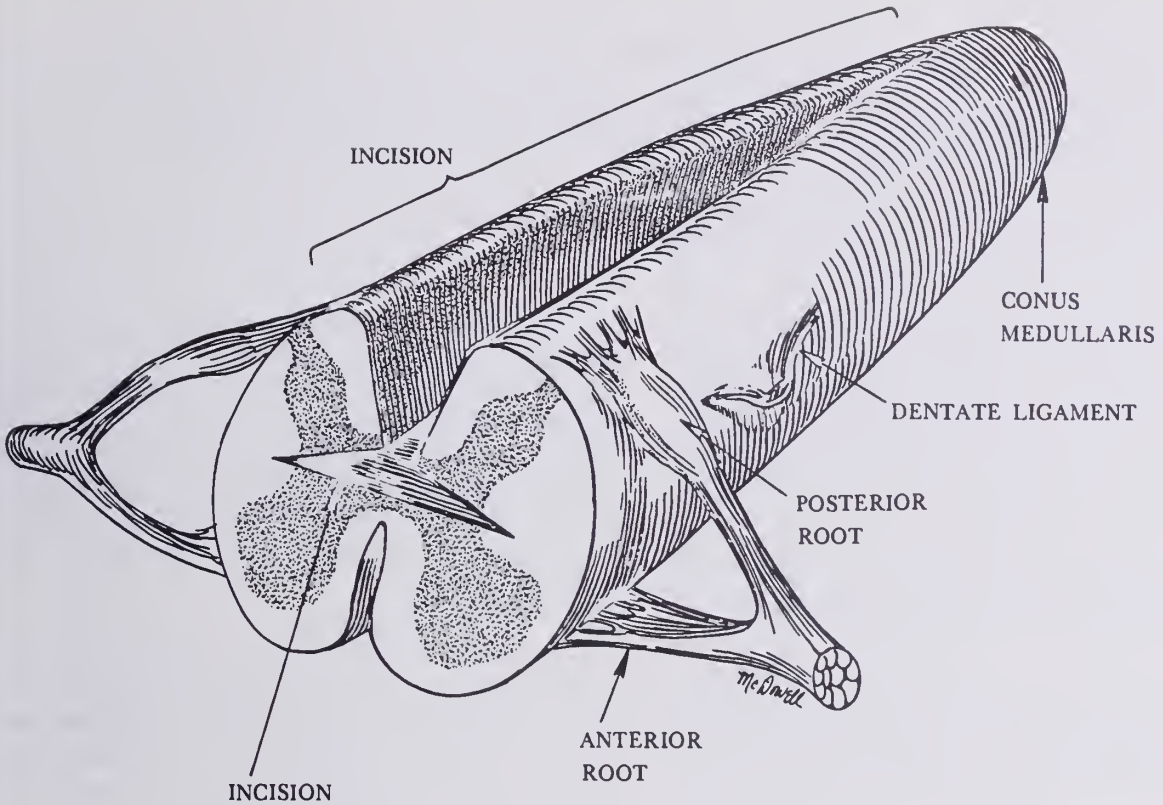


Fig. 2. — Demonstrating the later Bischof procedure; dorsal longitudinal myelotomy.

Case Reports

Case 1. — A 21-year-old man was rendered paraplegic by a C5-6 fracture-dislocation from a diving accident in 1970, two years prior to admission to The New York Hospital. Reduction and internal fixation were carried out shortly after the injury at another hospital. No recovery of motor or sensory function occurred caudal to the level of the lesion. Recurrent decubitus ulcers and contractures required multiple admissions. Extreme spasticity complicated the quadriplegia. Light stroking of the legs elicited severe flexor spasms. Flexor contractions of both knees and both hips confined him to an exaggerated "fetal" position in a water bed. Bladder and anal control were also absent. Multiple social problems and severe depression created an untenable existence. On March 20, 1972, a Bischof I myelotomy was performed with immediate relief of spasticity. Because of prior tendon lysis, the patient was able to transfer from his bed to a wheelchair. The pressure sores healed and the patient was transferred to a rehabilitation center. He is now four years post-operation with no recurrence of spasticity.

Case 2. — This 26-year-old girl was suddenly afflicted with paraplegia in February 1973. Cerebrospinal fluid (CSF) protein then was 192 mg% with no cells present. The diagnosis tendered at another institution was an acute attack of Guillain-Barre myeloneuropathy or an atypical form of multiple sclerosis. Neurological examination revealed a spastic paraplegia, hypalgesia to L2 on the left and L3 on the right, severe flexion spasms on stimulation of the lower extremities, and loss of vibration and position senses bilaterally. Partial anal and bladder control were present. Severe pain required increasingly higher doses of morphine sulfate for relief. Infected decubitus ulcers were refractory to therapy. Multiple tendon releases afforded no help. Many medical and emotional crises constantly drained the patient's and the staff's ability to deal effectively with her many problems. On December 10, 1974, the Bischof I myelotomy was performed with the addition of bilateral anterior cordotomies just cephalad to the myelotomy incision to insure pain relief. Following the surgical procedure, she was markedly improved. The spasticity was converted into a flaccid paraplegia. The painful spasms abated and addicting doses of morphine were tapered and finally discontinued. Bladder dysfunction was not increased and improved self-sanitary and toilet care were accomplished. She became cooperative, manageable and regained her appetite. She is now 19 months post-operation with no recurrence of spasticity, pain or spasms.

Case 3. — This 56-year-old lady underwent a midthoracic laminectomy in June 1970 for a radical excision of an arteriovenous malformation of the spinal cord. Residual postoperative neurological deficits included a mild paraparesis with decreased position and vibration senses. She accommodated well to the paresis through the years. However, in January, 1975 she experienced increasing weakness of her legs and the onset of painful flexor spasms in the thighs. Ambulation became increasingly difficult. Reflex and sensory functions were unchanged. Bladder and anal control persisted, though with some urinary incontinence. A course of physical therapy coupled with antispasmodic drugs did not help. Bilateral obturator neurectomies, performed to overcome the strong flexion and adduction contractions, provided relief for two months. The painful flexor spasms recurred. She was readmitted to the hospital in June 1975 when a Bischof II myelotomy was performed to alleviate the spasms and attempt to retain some of the diminishing motor function of the lower extremities. Following the operation, she was pain free and without flexor spasms. An increased weakness evolved which has not yet improved.

Case 4. — This 33-year-old lady first noted diplopia on right lateral gaze in 1967 at the birth of her first child. No other symptoms occurred at that time. She was well until 1969 when, following delivery of her second child, she again noted diplopia on right lateral gaze accompanied by decreasing vision O.S. and paresthesias of the fingers and toes. A year later she was confined to a wheelchair because of lower extremity weakness and imbalance. In February 1971 a lumbar puncture performed at another institution revealed an increased level of gamma globulin in the CSF and a diagnosis of multiple sclerosis was made. At that time, she complained of weakness of the right upper extremity and diplopia. Bladder urgency and frequency developed over a period of months in late 1971. A dorsal column stimulator was inserted at the T2 level in an attempt to aid ambulation. However, this was unsuccessful and after a trial of six months was removed. Progressive lower extremity weakness and contractures were accompanied by a need for bladder intubation. Pain and spasms elicited by light touch evolved. Severe flexion contractions ultimately required admission to The New York Hospital.

Physical examination revealed a woman with vision of 20/100 O.S., 20/40 O.D., pale discs, mystagmus in all directions of gaze, a sensory level to pin at T9-10 bilaterally, decreased position and vibration senses bilaterally with a level at T10, severe flexion contractions of the lower extremities, paraplegia and marked wasting and atrophy of the legs.

On March 15, 1976, she underwent a Bischof I myelotomy. Immediate results were gratifying. The pain and spasticity were relieved. Her legs could be extended to the limits of the hamstring tendons without difficulty. She is currently undergoing intensive physiotherapy.

Discussion

The spastic state, a remnant of normal coordination, is expressed by overactivity of motor neurones. Measures which reduce afferent impulses to the spinal cord may reduce hyperactivity and permit coordinated movements. Preservation and improvement of motor skills, sensation and visceral function with abolition of the hypertonicity are the goals in the care of the spastic patient. Spasticity can be controlled by three methods: (1) section of the afferent link of the reflex to reduce afferent stimuli; (2) section of the efferent limb to abolish the response; and (3) severing the connections between the two.

Table I outlines the procedures used for relief of spasticity.[3]

Table 1

Posterior Rhizotomy	Foerster 1910
Intrathecal Alcohol	Dogliotti 1930
Intrathecal Phenol	Suransa 1931
Anterior Rhizotomy	Munro 1945
Cordectomy	MacCarty 1948
Cauda Equina Transaction	Meirowsky 1950
Myelotomy	Bischof 1951

Table adapted after Ivan et al, reference 3.

Foerster advocated section of the posterior roots of L2-S1.[5] This affords only temporary relief at the price of a loss of residual sensation, with an attendant increased formation of bed sores. Intrathecal alcohol and phenol will yield temporary and unpredictable relief. Anterior rhizotomy will produce permanent paralysis and flaccidity, atrophy of the legs and loss of voluntary bladder function.[6,7] Cordectomy is a markedly final procedure. Cauda equina transection carries the disadvantages of the anterior and posterior rhizotomies. In short the main problem with these surgical procedures is that they either sacrifice all remaining function of the spinal cord, including sensory modalities, or if selectivity is desired, produce inconsistent results. Tenotomy, myotomy and neurectomy produce temporary rather than long term relief.

Conclusion

The results of the myelotomies performed on these four patients are encouraging. All experienced relief of spasticity. Complications were few. There were no infections or hematomas. One patient did experience an increased weakness of the lower extremities. This neurosurgical method is the most physiologic for the control of spasticity. Myelotomy is a useful form of therapy in advanced spasticity.

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The worst jolt most of us ever get is when we fall back on our own resources. — Kin Hubbard

Treatment of Multiple Sclerosis With Monoplace Hyperbaric Oxygenation

Richard A. Neubauer, M.D.

Dr. Neubauer's experience with hyperbaric oxygenation in the management of multiple sclerosis merits thoughtful reading. Though hardly conclusive, the results are clearly promising. The case report is presented in the hope that definitive research might be stimulated.—E. Charlton Prather, M.D., Associate Editor.

Twelve patients with multiple sclerosis (MS) have been treated with hyperbaric oxygenation (HBO) and ten of them have shown partial to total improvement for periods ranging from four months to two years.

Case Reports

Case 1. — This 62-year-old white man was hospitalized May 23, 1977 in order to receive HBO treatment for multiple sclerosis. He first experienced symptoms of MS in 1944 when his hands became numb. By 1958 he was using a cane and by 1963 a wheelchair most of the time. Since 1968 he has not been able to walk. For the last two and one half years he has been receiving megavitamin therapy with vitamins C and E and has used numerous patent medicines.

At the time of admission, physical examination revealed a patient with severe, advanced debilitating MS. He was confused all the time. There was progressive neuromuscular deformity in the arms and legs with much atrophy of the musculature. The left arm was extremely weak and the left leg almost useless. The patient did not have aphasia or slurred speech but did have difficulty reading due to "jerking eyes." There was a Lhermitte's sign and a bilateral positive Homans' sign. Psychologically he appeared in good spirits.

During his hospital stay of 22 days the patient received 62 HBO treatments. There was marked improvement in his mental confusion. An EEG done on the second day of his hospital stay revealed a moderate, diffused disturbance of all functions without localizing features. Eight days later a second EEG showed significant improvement over the earlier one and revealed minimal disturbance in normal function. The patient had slightly more feeling and spastic movement.

Now four months after his first HBO treatment he has had an additional seven treatments and is continuing at one treatment a month. He can stand momentarily while being moved from wheelchair to bed; his back and head are straighter and his left arm is stronger. He is able to very actively move his legs while in the pool. His bladder control has improved but is still a problem with chronic infection. He is mentally alert.

Case 2. — A 57-year-old white woman, who had been confined to a wheelchair for two years after a 16-year course of MS, began HBO treatments May 10, 1977. After 25 treatments in the hospital she was walking more and more each day and using all extremities and going into a complete remission. After leaving the hospital she returned home to a distant state where she found it difficult to travel a long distance for biweekly HBO treatments. There was some deterioration. She missed a number of treatments but when she was able to take them she felt significant improvement for four to five days following each. She is still ambulatory. She is to be admitted to the hospital where she is scheduled for an intensive course of HBO. It is hoped she will be able to continue treatment regularly afterward.

Discussion

Warren, Sacksteder and Thuning[1] reported on the modification of allergic encephalomyelitis in guinea pigs receiving HBO. This is an analogous disease to MS in humans.

The patients in this limited series were exposed to compressed oxygen in a monoplace hyperbaric oxygen chamber at one atmosphere absolute (ATA) usually for two hours a day for the first four treatments. The next four treatments were at 1.5 ATA and subsequent treatments at 2 ATA. Later treatments were spread out more, usually to once a week for a period and then once a month. All patients were advised that HBO might produce a remission but probably would not result in long-term benefits. There were no side effects from the HBO except for minor ear problems in two cases.

It is well known that in the later stages of MS remissions rarely occur.[2] Yet, each of the patients in this series improved to some degree and, except for two, retained that improvement for periods of four months to two years, even though most had had MS for many years.

Although this study on 12 patients cannot be considered conclusive, I feel that it offers enough information to warrant further study since none of the patients developed any contraindications to HBO and with two exceptions all benefited to some degree. I have been unable to find further references to HBO treatment of MS in the English literature.

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Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

Time is the test of all things



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It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

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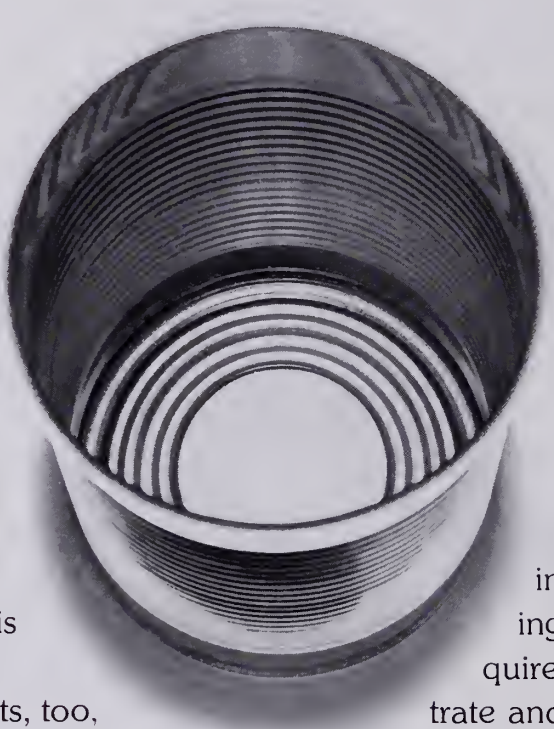
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SPECIAL ARTICLE

The Past, Present and Future of Medicine and Medical Education

John M. Thompson, M.D.

I would like to take this opportunity to sincerely thank the Class of 1977 for the privilege of delivering your Commencement Address. This is one of the greatest honors that I have had in my entire life. I do not deserve this honor, but fortunately honors do not have to be deserved in order to be appreciated. What qualifications do I actually have to deliver your Commencement Address? You could have chosen someone with far more intelligence. I am well aware that my intellectual ability is only mediocre. The one qualification that I seem to have is the ability to understand the emotions of most of the people in this auditorium. I can easily understand the emotions of those of you who are graduating today because time has done little to dim the memory of my own graduation from medical school 29 years ago on June 8, 1948. I can well understand the emotions of the members of the faculty gathered here today as I have been on the faculty of three medical schools and know the sense of satisfaction that comes to teachers when they see former students pass such an important milestone. There are spouses in the audience who have come to see their mates receive their M.D. degree. I had been married for a year when I received my M.D. degree and my wife was there when I was handed my diploma. I feel that I know and understand something of her emotions at the time. It is particularly easy to relate to and understand the emotions of parents in this audience. It was just 52 weeks ago today that I sat in the audience and listened to a Commencement Address given by Dr. Jeffrey Ellison when our daughter graduated from Tulane University School of Medicine. Dr. Ellison, a neurologist, had helped teach our daughter neuroanatomy during her first year of medical school. Fifteen days ago my wife and I sat in the same quadrangle in which I had received my M.D. degree and saw our son receive his B.A. degree after completing two years of the special five year program at the Johns Hopkins University School of Medicine. We hope to be back in another three years to hear another Commencement Address and see our son receive his M.D. degree. I hope that I have convinced you by now that I understand something of your feelings. If you have a sense of pride do not be ashamed of it; not only have the graduates worked long and hard for this day, but many others in the audience have sacrificed much to help these fine young people. I would rather give a Commencement Address here in Tampa than any place on the face of this planet. This is the city where I have my roots. I was a product of a home delivery by a general practitioner in the Tampa Heights section of Tampa. I went through public schools in Tampa graduating from Hillsborough High School one month after Pearl Harbor was bombed. I wanted to go into medicine but there were no medical schools then in the entire state of Florida.

Approximately 32 months ago during the course in neuroanatomy I gave you some advice that I had found valuable when I was in medical school. The wisdom did not come from me but rather from Sir William Osler, the first professor of medicine at Johns Hopkins, who wrote a book entitled "A Way of Life." Dr. Osler stated that life should be lived one day at a time and that if a person had a strabismus with one eye on yesterday and the other eye on tomorrow that he was very apt to stumble on today. This is good advice but I feel that at least once in a person's life, on his or her graduation day, that a brief look back and a brief look forward is permissible. I, therefore, would like to briefly discuss, "The Past, Present and Future of Medicine and Medical Education." I will repeat some things I told this class during the first year. To many of you what I say today will be elementary; however, the back-

This Commencement Address was presented before the graduating class of the University of South Florida College of Medicine on June 11, 1977.

ground of those here today varies considerably, and I would like to be understood by all.

The Past

It is not possible to precisely fix the date of the dawn of medicine on the planet earth. We know that even primitive stone age tribes had their medicine men. We do not know whether medicine men were selected because of their superior intelligence and superior skill or whether they were relegated to their positions because they were inferior hunters and fishermen. My own specialty of neurological surgery has been practiced for over 10,000 years as skulls have been discovered in caves in Bohemia which showed evidence that neurosurgeons then were able to successfully open the skull. There was considerable specialization in ancient Egypt and Egyptian writings described internists, ophthalmologists, gastroenterologists, and head physicians. The proctologists apparently enjoyed great esteem as they were referred to as "shepherds of the anus." The Greeks made great advancements in medicine and even Hippocrates practiced neurological surgery in that he trephined for skull fractures, epilepsy, blindness, and headaches. I doubt that many of his patients complained of tension headaches.

During the Middle Ages there was considerable deterioration in the art of surgery. Physicians retreated and the barbers advanced, annexing the declining art of surgery. However, with the Renaissance in Europe there arose in the College de St. Come a group of educated surgeons who after studying medicine and philosophy took a two year course in surgery. Wishing to distinguish themselves from barber surgeons who wore short robes, these educated surgeons wore long robes. We can thus see that the battle between the maxi and mini was not started by women but rather by men hundreds of years ago. I would like to suggest that this matter be resolved by having male physicians wear long robes or the equivalent and female physicians wear short robes. One does not have to be an anatomist to realize that legs were not created equal. Even the Supreme Court should recognize this. Male legs may be functional but certainly are not objects of beauty like female legs.

The Renaissance brought a new awakening but progress for many centuries was pitifully slow. In December 1799 ex-president Washington rode a horse in the freezing rain to oversee the activities on his plantation, Mount Vernon. The following day George Washington had a sore throat. A physician was summoned who prescribed the then popular treatment of bleeding. A unit of blood was taken from George Washington. Washington's condition did not improve. The attending physician felt that he was on a spot. After all he was treating the first president of the United States so he requested a consultation. The second physician examined George Washington and decided that Washington needed to be relieved of another unit of blood. Washington then became somewhat weaker and did not seem to be responding to the treatment. It was therefore decided that a third consultation was in order. A young physician was called in from Alexandria and he first opposed further bloodletting but finally these three physicians agreed George Washington should have another unit of blood withdrawn. Following this Washington's pulse became thready and weak and he expired. If Washington had been a slave on the plantation he probably would have recovered from his sore throat but since he was a planter he died of his medical treatment. Medicine had done to George Washington what the British Armies had been unable to do.

Occasionally in the 19th century a physician of superior intelligence tried to change the establishment. Dr. Ignaz Philipp Semmelweis was such a physician. At the age of 28 he was appointed first assistant in the First Obstetrical Clinic of the Vienna General Hospital. He observed that the maternal mortality was much higher for women who had their babies in the hospital than for women who had their babies at home. Maternal mortality also was much higher in the First Obstetrical Clinic in which medical students did many of the deliveries than in the Second Obstetrical Clinic where midwives did most of the deliveries. Dr. Semmelweis noted that many medical students and attending physicians did autopsies in the basement and then went upstairs to perform deliveries without washing their hands. The maternal mortality rate in May 1847 in the First Obstetrical Clinic was 12.24%. Dr. Semmelweis then introduced the revolutionary concept of washing the hands in calcium chloride before deliveries were done and the results were dramatic. The mortality rate dropped from 12.24% in May to 2.38% in June, and to 1.20% in July. However, Professor Kline, Chief of Obstetrics, refused to accept this advance and apparently felt that washing hands was a waste of natural resources. Semmelweis published his monumental work in 1860 but unfortunately he was very sensitive to criticism and in 1864 showed definite evidence of mental disease. He died in 1865 at the age of 47 of an infected finger.

Hospitals in the 19th century were filthy and infested with rats. During a single evening 40 rats were killed in one bathroom at Belleview Hospital in New York. There was no professional nursing training in the United States until 1873 when the Belleview School of Nursing was established. Prior to that time prostitutes and drunk women were committed to work out their sentences in hospitals rather than going to jail. These prostitutes and alcoholics were the nurses. The standards for physicians were not much higher than for nurses. Dr. Charles Elliott tried to introduce written examinations into the Harvard Medical School but his request was denied in 1869 by the dean, because the dean felt that the majority of the students could not write well enough to take written examinations.

My grandmother lived on a farm in central Georgia. There seemed to be an advantage then in digging a well in low ground so that it would not be so far down to the water and there seemed to be an advantage in building the outhouse on high ground so people would not get their feet muddy when going to the outhouse. Obviously sewage drained from the outhouse to the well. Such probably explains why my grandmother developed typhoid fever when she was 41 years old. As many of you know, typhoid fever usually results in very severe diarrhea and dehydration. A country physician was called and prescribed calomel which is a very strong laxative. My grandmother died a day or two later leaving ten children including a four-month-old baby without a mother. She might have died of typhoid fever without a physician but the calomel prescribed by the physician took away her only chance for life.

The Johns Hopkins University School of Medicine opened in 1893. Johns Hopkins required at least a Bachelor's Degree from college of all entering students. The best way to have a good school is to have good students and Hopkins attracted many bright men and women who were well educated in arts and sciences before starting medical school. All the advances at Johns Hopkins, however, were not based on intelligence. Dr. William Halsted, Chief of Surgery, started dating one of the operating room nurses. Strong antiseptics caused her to have a rash on her hands and Dr. Halsted introduced rubber gloves in surgery to help protect the delicate hands of his girlfriend. He then recognized that what was good for the goose was also good for the gander.

Early in this century the Flexner report did much to upgrade medical education. Medical schools that did not meet Class A standards were closed. The quality of the medical students improved considerably, but the quality of life for medical students left much to be desired. Many schools had a compulsory flunk rate. A friend of mine was told when he entered Tulane University in 1938 that 50% of the students would be failed during the first two years, and 50% of the students were failed during the first two years. Those who made it through medical school graduated in 1942 and then entered the Armed Forces after a nine month internship. Thirty percent of the 50% who graduated were killed in action during World War II.

Failure and war, however, were not the only problems for medical students and young physicians. Tuberculosis was a common disease among medical students, interns, and residents. A physician that I know well told me that he developed tuberculosis during his residency. He was sent to a TB sanitorium in the mountains of upstate New York. The open air method of treatment of tuberculosis was then in vogue. He told me he was placed in a screened-in porch and given lots of fresh air. At times during the winter the temperature dropped to 40 degrees below zero and he would wake up in the morning with a foot of snow covering his blankets. Obviously many physicians and nurses in those sanitoriums never survived the treatment. Ten percent of my own medical school class developed tuberculosis either during medical school or shortly thereafter. One girl in my class died of tuberculosis at the end of the first year of medical school.

Internship implied a person would be interned in the hospital for a year. The interns lived, ate, and worked in the hospital for room and board and no salary. They really did not need "pocket money" for recreation as there was no time for recreation. Interns were expected to be on duty 24 hours a day, seven days a week. An intelligent young lady in my class at Johns Hopkins was accepted for the prestigious Osler Internship at Johns Hopkins. Another young lady from another medical school also was accepted the same year for an Osler Internship. The other young lady was married but her husband was interning at Duke University. She suggested to my classmate that they alternate weekends on call so that she would be able to fly down to Duke on Saturday afternoon to see her husband over the weekend. This meant that the intern on call carried an unusually heavy load. Residents on the Osler Service became quite upset with this arrangement and called the two lady interns in and told them that if they were not willing to give up a year of their life for medicine they should get out of the medical

profession. The residents themselves worked long hours and they had little patience with interns who could not work long hours. Most services had a pyramid system whereby only about one fourth the interns on the service were invited to stay on for residency, and eventually only one person per year would become Chief Resident for that service. This system produced a few superbly trained specialists who were the olympic stars in medicine. They were long distance runners who could survive on little sleep, little money and little recreation. However, the system did not provide the quantity of well trained physicians and surgeons to take care of the majority of the people in the United States.

Unfortunately there have been fashions or vogues in medicine as there have been in many other aspects of life. For many decades Medicine was preoccupied with the bowels because drugs had been developed that could either speed up or slow down the bowels. I was raised in such an era of medicine. My mother frequently gave us children prophylactic castor oil or milk of magnesia on Friday night so we would be healthy the following week and would not miss any school. If I swallowed a cat hair I would receive a laxative. I mentioned that my grandmother died as a result of this fashion in medicine. Many physicians ruptured appendices by prescribing laxatives. Many nurses were taught that the main emphasis in nursing care was to clean out the lower intestine daily. I well recall some years ago when I was the only neurosurgeon or neurologist in Pinellas County, and had been working very long hours and had very little time for my family. Finally an hour of freedom came and I took my wife to a restaurant on the Tampa side of Gandy Bridge. I told the medical exchange to call me at the restaurant only for emergencies. Then just as our steaks were being served, a waitress came in and stated that there was an urgent phone call for me. A special duty nurse on the other end of the line apologized for calling me but stated that she felt I would enjoy my dinner much more if I knew that a certain patient had just had a bowel movement. The patient was comatose with an inoperable brain tumor and was unable to appreciate the bowel movement but the nurse just had to share her good news with someone.

You have learned much during your three years in medical school at the University of South Florida. Most of what you have learned is true and will stand the test of time; however, I hope that you will not assume that everything was gospel. I well remember when I was in medical school that a now famous scientist lectured to our class on poliomyelitis. He showed us slides indicating virus activity in the olfactory tracts and explained that polio virus entered the brain through the olfactory nerves that extended into the nasopharynx. He stated that since the virus penetrated the nerves directly rather than going through the blood stream it would be impossible to ever develop a polio vaccine. Fortunately, what he taught was later proved to be false as it was discovered that the polio virus does indeed travel through the blood stream and it was possible to make the polio vaccine.

I have told you a great deal of what has been wrong with medicine in the past. I have told you that many patients would have done better without professional medical help. Dr. Oliver Wendell Holmes, poet and physician, stated in the last century: "If the whole materia medica as now used could be sunk to the bottom of the sea, it would be all the better for mankind, and all the worse for the fish." However, much good was done in the past and I am a living example of what can be done with good medical care. During the 1930's I went with my family on our yearly vacation to Dooley County, Georgia. Most of you have never heard of Dooley County but it is about 25 miles from Plains, Georgia. While playing in the woods an insect bit my right little finger. The wound became secondarily infected and I then developed an ulnar bursa infection which communicated with my radial bursa. I developed massive swelling of the entire right upper extremity and my arm became two to three times the normal size. I had lymphangitis with red streaks going up my arm and chills and fever developed. This was before any of the antibiotics had been discovered. In retrospect I probably had a beta hemolytic streptococcus infection and could have easily died of what then was commonly known as "blood poisoning," and medically as septicemia. My father took me to a general practitioner in a small town about the size of Plains. He opened my ulnar bursa under local anesthesia in his office and drained out a large pan full of pus. I mentioned to you earlier that Semmelweis died of an infected finger and fortunately my country physician had a better result than his city physician.

The Present

Let us look at medicine and medical education of the present. Much is known about the anatomy, physiology and biochemistry of the body. There are a variety of antibiotics that are effective in most bacterial infections. Viral infections have thus far

been resistant to most antibiotics but some chemicals such as amantadine have been developed which are antiviral. Anesthesia has been developed to the point where true anesthetic mortality is very low. Surgery is successfully performed on all the organs of the body and several organs can now be transplanted from one human to another. Maternal and infant mortality rates have been dramatically reduced in most nations. Preventive medicine has greatly increased life expectancy in every continent.

Medical schools now attract some of the most intelligent, emotionally stable, and best motivated students in our society. The quality of medical students now is better than it has ever been in the past and I doubt that the quality of the students can be improved upon in the future. We are already getting the best. It is recognized that all medical students are not cut out of the same pattern and that each medical student not only has different fingerprints but also different intellectual and emotional talents. Students enter medical school with many different majors and many different backgrounds. There are three, four, and five year programs in various medical schools. None of these programs are ideal for all types of medical students. The problem is to pick the medical students who would do best with a particular type of program. It is impossible to teach students in three, four or five years all that is known about medicine so there has been considerable revision of the curriculum in most medical schools trying to achieve the best balance.

As you know there are now three medical schools in the state of Florida. Each school is unique. The University of South Florida College of Medicine has made fantastic progress in the short period of time it has been in existence. I would like to pay tribute today to the genius of Dr. Donn L. Smith who was the master architect for this medical center. He combined Art and Science in an efficient, functionally beautiful manner. We all owe Dr. Smith a debt of gratitude.

I felt somewhat ill at ease when I approached internship and realized that the decisions I made during the internship would affect the health and lives of many people and I realized how much medicine I did not know. This is a normal emotional reaction for those who are awarded the M.D. degree. I would like to reassure the graduates that you are well prepared to enter your residency training programs. Your colleagues in the medical profession will be happy to help you when you do need help. You will work long hours and many of you will experience fatigue. The work week in general has been reduced from over 120 hours to about an average of 80 hours. You will have an occasional evening off and an occasional weekend off. You will not become wealthy on your salary but salaries are considerably more than room and board. Our daughter's income has been over $16,000 at the St. Vincent's Hospital in New York in her first year out of medical school. Many people think of the past as "the good old days" in regards to medicine and medical education. These are the good days in the present.

The Future

Now let's look into the future. Chemotherapy of viral diseases will become more specific and more effective. Chemotherapy of cancer will also become much more effective. Microsurgery will extend the frontiers of surgery to smaller and smaller structures and synthetic materials will be developed which will be better tolerated by the human body. More and more joints will be replaced and more and smaller, badly diseased blood vessels will be replaced. An effective, efficient artificial heart will be developed and will replace heart transplants. People will not only have more quantity to life but also more quality to life. The aging process will be retarded but will not be eliminated.

What does the future hold for medical education? How can education in general and medical education in particular be more efficient? Students at all levels of education should be permitted to advance at their own pace. Many students could complete elementary school in less than six years. The senior year in high school is less important academically and yet is very important emotionally and socially to many students. However, I will predict that more and more students will be going to college after completing the junior year of high school. The senior year of college is also less important for medicine than the other three years; however, as I indicated to you previously I feel that it is very important to have a variety of programs for students of different backgrounds and different interests.

Much has been said about the maldistribution of physicians. Actually physicians now are pretty well distributed according to the population. Most rural areas and small towns are not far from hospitals and patients can usually be transported quickly over interstate highways or even by planes. However, it is likely that physicians will disperse to small towns. Medical care for those who dwell in the ghettos will create more of a problem. The solutions

are not simple. I have a friend who practiced in a marginal area and he was stabbed in the chest when he opened the back door of his office and on another occasion a patient's relative pulled a gun on him and forced him to change an insurance form. It is not going to be possible to get many physicians and nurses in ghetto clinics and medical offices until the ghettos can be made reasonably safe.

Much has been written and said about the socio-economic of medicine. Talk of National Health Insurance probably has created more hypertension in physicians than salt. I suspect that there will be National Compulsory Catastrophic Health Insurance. I personally would not oppose such a plan as I feel that one of the functions of government is to help citizens out in catastrophic situations. This actually is not a new concept but a concept thousands of years old. Leper colonies were created to care for lepers. TB sanitoriums were created by the state to care for those with tuberculosis. One might argue that these colonies and hospitals were establishd to segregate these patients from society. However, psychotic patients also have been cared for by the state even though it was recognized that psychosis is not an infectious disease, although it is certainly a catastrophic illness. It has been the proper function of government to help the victims of earthquakes, tidal waves, and hurricanes. These are catastrophic situations and illness and accidents at times are also catastrophic.

However, I do not feel that people should ask government to do for them what they are better able to do for themselves. The least expensive food that a person can buy is usually purchased directly from a farmer. The more middle men there are between the farmer and the consumer the higher the price of the food. Likewise in medical care the least expensive medical care is the care purchased directly from the provider. The more middle men there are in between, including governmental employees, the more expensive the care will be. I feel that taxpayers could not afford the cost of Comprehensive National Health Insurance which would be administered by the federal government.

I hope all of you are developing a philosophy of life which will sustain you for the years that lie ahead. It is actually more difficult to do philosophy transplants than heart transplants or kidney transplants. Philosophy must be something that develops within your own brains. Two members of my own medical school class later committed suicide and unfortunately suicide is not uncommon in the medical profession. With the proper philosophy you can find medicine immensely satisfying. An example might illustrate my point. A little over two years after I graduated from medical school I was an assistant resident in surgery at the University of Michigan Medical Center. I was rotating through thoracic surgery and was preparing to do a thoracentesis one Saturday night when a nurse interrupted me for an urgent telephone call. My wife tearfully informed me that I had just received orders that I was being called to active duty in the Naval Reserve and was to report to Fort Sam Houston, Texas, the following Thursday in uniform. The Navy was loaning me to the Army. When I arrived at Fort Sam Houston I was told that the Army might find it necessary to send a few of the unmarried Naval Officers to Korea. I breathed a sigh of relief as my wife had just given birth to our first child two months previously. I was told that the Army was very interested in those medical officers who had had training in research, and since I had had a National Research Council Fellowship in neurophysiology for a year at Johns Hopkins, I thought it was likely that I would be assigned to a research position at the Walter Reed Hospital in Washington, D. C.; however, when my orders came through I found that they had counted my year of operating upon rabbit brains as a year as surgical residency and that I was thus classified as a surgeon, and I was ordered to report to the Second Mobile Army Surgical Hospital. I was told that this particular MASH unit was "hot" and that I should make out a will and take out more life insurance. The medical officers were issued 45 caliber pistols and carbine rifles and when we first started operating in Korea we surgeons wore our 45's under our surgical gowns. There was some philosophical discussions as what we should do if our hospital was overrun by the enemy. We were the forward MASH unit and at times were rather close to the enemy. If our hospital was overrun by the enemy, should a surgeon abandon his patient and flee, should he pull out his 45 and fight, should he pull out his 45 and help protect the nurses from being raped, or should he continue operating upon his patient? Unfortunately, such discussions do not lend themselves to seminars and philosophy. I don't remember when it was that I stopped carrying my 45 to the operating tent. Actually five of the six surgeons in our MASH unit made the same decision. We each had made our own decision that our primary responsibility was to the patient. Our working day was 36 hours of assembly line surgery and I am not ashamed of the fact that I frequently fell asleep while operating. We not only did sponge counts but also fly counts

as there were usually many flies around the intestines when we did laparotomies. It was always reassuring to have the same fly count after the peritoneum was closed as we had when the peritoneum was open. There was a machine gun nest only about 20 feet from where I slept but I had no problems with insomnia. I knew that there were a lot better surgeons in the world than I was, but I was there and most of them were not. I had the responsibility and the only way that I could live with my own brain was to accept the responsibility and do the best that I could under the circumstances. I saw many horrible things in Korea and yet I have never had any war nightmares. I got two battle stars for being there but I never got the Bronze Star, Silver Star, or the Navy Cross. I did not get them because I didn't deserve them. I had done nothing extraordinary. I had only done my duty. I had developed a philosophy of life that I could either live with or die with. I hope that your own experiences in the next few years will convince you that you must live happily with your own brains.

I sincerely hope that someday you will look down on me. Physically this will not be difficult as I am not very tall. However, I hope intellectually you also will look down on me. If you do not I will have been a failure as a teacher. The Indians in Florida had a practice of building mounds. Each generation added to the mound and each generation could climb a little higher and see a little further. We in medicine must build our own mound and your generation of physicians must be able to climb higher and look further than my generation of physicians. I closed one of my lectures to you with the following story and I would like to share it with you again. The nervous system consists of a marvelous computer and many cables carrying information to and from the computer. Telephone repairmen do a reasonably good job repairing cables, but those of us in the neurological field are frequently frustrated because in many parts of the nervous system cable repairs have not been successful. I will always remember a medical meeting that I attended seven years ago and heard a British neurosurgeon, Mr. Walpole Lewin, present a paper, "Towards a Visual Prosthesis." Mr. Lewin realized that the eyes are merely television cameras and that the optic nerves and optic tracts are merely television cables. He realized that the television screen was actually in the back of the brain and that we now should be able to bypass the eyeballs, optic nerves, and optic tracts. He devised a small television camera which a person could wear on a skull cap and then fashioned small cables to carry the electrical impulses to the back of the head. He constructed a small transmitter to transmit the impulses across the intact scalp and devised a receiver to pick up these impulses and relay them to a stimulator placed over the visual cortex or television screen. Obviously amplifiers also were used. After much work he was finally ready to implant the unit in a human being. He implanted the unit in a lady who had been blind for many years. He then placed her in a dark room and turned on a light and asked her what she saw. She replied, "I see a star." Out of the pitch blackness she finally had seen a star and again had hope. However, she was able to see a star only because Mr. Lewin had seen a star earlier and had followed that star in spite of many trials and frustrations. Wise men have seen and followed a star for thousands of years.

The practice of medicine can best be described by a song in the "Man of LaMancha."

To dream the impossible dream,
To fight the unbeatable foe,
To bear with unbearable sorrow
To run where the brave dare not go.

To right the unrightable wrong,
To love, pure and chaste from afar,
To try, when your arms are too weary,
To reach the unreachable star!

This is my quest, to follow that star,
No matter how hopeless, no matter how far,
To fight for the right without question or pause,
To be willing to march into hell
for a heavenly cause,

And I know, if I'll only be true to this
glorious quest,
That my heart will lie peaceful and calm
when I'm laid to my rest.

And the world will be better for this,
That one man, scorned and covered with scars,
Still strove, with his last ounce of courage,
To reach the unreachable star!

▶ Dr. Thompson, 741 Twelfth Street North, St. Petersburg 33705.

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SPECIAL ARTICLE

The Past, Present and Future of Medicine and Medical Education

John M. Thompson, M.D.

I would like to take this opportunity to sincerely thank the Class of 1977 for the privilege of delivering your Commencement Address. This is one of the greatest honors that I have had in my entire life. I do not deserve this honor, but fortunately honors do not have to be deserved in order to be appreciated. What qualifications do I actually have to deliver your Commencement Address? You could have chosen someone with far more intelligence. I am well aware that my intellectual ability is only mediocre. The one qualification that I seem to have is the ability to understand the emotions of most of the people in this auditorium. I can easily understand the emotions of those of you who are graduating today because time has done little to dim the memory of my own graduation from medical school 29 years ago on June 8, 1948. I can well understand the emotions of the members of the faculty gathered here today as I have been on the faculty of three medical schools and know the sense of satisfaction that comes to teachers when they see former students pass such an important milestone. There are spouses in the audience who have come to see their mates receive their M.D. degree. I had been married for a year when I received my M.D. degree and my wife was there when I was handed my diploma. I feel that I know and understand something of her emotions at the time. It is particularly easy to relate to and understand the emotions of parents in this audience. It was just 52 weeks ago today that I sat in the audience and listened to a Commencement Address given by Dr. Jeffrey Ellison when our daughter graduated from Tulane University School of Medicine. Dr. Ellison, a neurologist, had helped teach our daughter neuroanatomy during her first year of medical school. Fifteen days ago my wife and I sat in the same quadrangle in which I had received my M.D. degree and saw our son receive his B.A. degree after completing two years of the special five year program at the Johns Hopkins University School of Medicine. We hope to be back in another three years to hear another Commencement Address and see our son receive his M.D. degree. I hope that I have convinced you by now that I understand something of your feelings. If you have a sense of pride do not be ashamed of it; not only have the graduates worked long and hard for this day, but many others in the audience have sacrificed much to help these fine young people. I would rather give a Commencement Address here in Tampa than any place on the face of this planet. This is the city where I have my roots. I was a product of a home delivery by a general practitioner in the Tampa Heights section of Tampa. I went through public schools in Tampa graduating from Hillsborough High School one month after Pearl Harbor was bombed. I wanted to go into medicine but there were no medical schools then in the entire state of Florida.

Approximately 32 months ago during the course in neuroanatomy I gave you some advice that I had found valuable when I was in medical school. The wisdom did not come from me but rather from Sir William Osler, the first professor of medicine at Johns Hopkins, who wrote a book entitled "A Way of Life." Dr. Osler stated that life should be lived one day at a time and that if a person had a strabismus with one eye on yesterday and the other eye on tomorrow that he was very apt to stumble on today. This is good advice but I feel that at least once in a person's life, on his or her graduation day, that a brief look back and a brief look forward is permissible. I, therefore, would like to briefly discuss, "The Past, Present and Future of Medicine and Medical Education." I will repeat some things I told this class during the first year. To many of you what I say today will be elementary; however, the back-

This Commencement Address was presented before the graduating class of the University of South Florida College of Medicine on June 11, 1977.

ground of those here today varies considerably, and I would like to be understood by all.

The Past

It is not possible to precisely fix the date of the dawn of medicine on the planet earth. We know that even primitive stone age tribes had their medicine men. We do not know whether medicine men were selected because of their superior intelligence and superior skill or whether they were relegated to their positions because they were inferior hunters and fishermen. My own specialty of neurological surgery has been practiced for over 10,000 years as skulls have been discovered in caves in Bohemia which showed evidence that neurosurgeons then were able to successfully open the skull. There was considerable specialization in ancient Egypt and Egyptian writings described internists, ophthalmologists, gastroenterologists, and head physicians. The proctologists apparently enjoyed great esteem as they were referred to as "shepherds of the anus." The Greeks made great advancements in medicine and even Hippocrates practiced neurological surgery in that he trephined for skull fractures, epilepsy, blindness, and headaches. I doubt that many of his patients complained of tension headaches.

During the Middle Ages there was considerable deterioration in the art of surgery. Physicians retreated and the barbers advanced, annexing the declining art of surgery. However, with the Renaissance in Europe there arose in the College de St. Come a group of educated surgeons who after studying medicine and philosophy took a two year course in surgery. Wishing to distinguish themselves from barber surgeons who wore short robes, these educated surgeons wore long robes. We can thus see that the battle between the maxi and mini was not started by women but rather by men hundreds of years ago. I would like to suggest that this matter be resolved by having male physicians wear long robes or the equivalent and female physicians wear short robes. One does not have to be an anatomist to realize that legs were not created equal. Even the Supreme Court should recognize this. Male legs may be functional but certainly are not objects of beauty like female legs.

The Renaissance brought a new awakening but progress for many centuries was pitifully slow. In December 1799 ex-president Washington rode, a horse in the freezing rain to oversee the activities on his plantation, Mount Vernon. The following day George Washington had a sore throat. A physician was summoned who prescribed the then popular treatment of bleeding. A unit of blood was taken from George Washington. Washington's condition did not improve. The attending physician felt that he was on a spot. After all he was treating the first president of the United States so he requested a consultation. The second physician examined George Washington and decided that Washington needed to be relieved of another unit of blood. Washington then became somewhat weaker and did not seem to be responding to the treatment. It was therefore decided that a third consultation was in order. A young physician was called in from Alexandria and he first opposed further bloodletting but finally these three physicians agreed George Washington should have another unit of blood withdrawn. Following this Washington's pulse became thready and weak and he expired. If Washington had been a slave on the plantation he probably would have recovered from his sore throat but since he was a planter he died of his medical treatment. Medicine had done to George Washington what the British Armies had been unable to do.

Occasionally in the 19th century a physician of superior intelligence tried to change the establishment. Dr. Ignaz Philipp Semmelweis was such a physician. At the age of 28 he was appointed first assistant in the First Obstetrical Clinic of the Vienna General Hospital. He observed that the maternal mortality was much higher for women who had their babies in the hospital than for women who had their babies at home. Maternal mortality also was much higher in the First Obstetrical Clinic in which medical students did many of the deliveries than in the Second Obstetrical Clinic where midwives did most of the deliveries. Dr. Semmelweis noted that many medical students and attending physicians did autopsies in the basement and then went upstairs to perform deliveries without washing their hands. The maternal mortality rate in May 1847 in the First Obstetrical Clinic was 12.24%. Dr. Semmelweis then introduced the revolutionary concept of washing the hands in calcium chloride before deliveries were done and the results were dramatic. The mortality rate dropped from 12.24% in May to 2.38% in June, and to 1.20% in July. However, Professor Kline, Chief of Obstetrics, refused to accept this advance and apparently felt that washing hands was a waste of natural resources. Semmelweis published his monumental work in 1860 but unfortunately he was very sensitive to criticism and in 1864 showed definite evidence of mental disease. He died in 1865 at the age of 47 of an infected finger.

Hospitals in the 19th century were filthy and infested with rats. During a single evening 40 rats were killed in one bathroom at Belleview Hospital in New York. There was no professional nursing training in the United States until 1873 when the Belleview School of Nursing was established. Prior to that time prostitutes and drunk women were committed to work out their sentences in hospitals rather than going to jail. These prostitutes and alcoholics were the nurses. The standards for physicians were not much higher than for nurses. Dr. Charles Elliott tried to introduce written examinations into the Harvard Medical School but his request was denied in 1869 by the dean, because the dean felt that the majority of the students could not write well enough to take written examinations.

My grandmother lived on a farm in central Georgia. There seemed to be an advantage then in digging a well in low ground so that it would not be so far down to the water and there seemed to be an advantage in building the outhouse on high ground so people would not get their feet muddy when going to the outhouse. Obviously sewage drained from the outhouse to the well. Such probably explains why my grandmother developed typhoid fever when she was 41 years old. As many of you know, typhoid fever usually results in very severe diarrhea and dehydration. A country physician was called and prescribed calomel which is a very strong laxative. My grandmother died a day or two later leaving ten children including a four-month-old baby without a mother. She might have died of typhoid fever without a physician but the calomel prescribed by the physician took away her only chance for life.

The Johns Hopkins University School of Medicine opened in 1893. Johns Hopkins required at least a Bachelor's Degree from college of all entering students. The best way to have a good school is to have good students and Hopkins attracted many bright men and women who were well educated in arts and sciences before starting medical school. All the advances at Johns Hopkins, however, were not based on intelligence. Dr. William Halsted, Chief of Surgery, started dating one of the operating room nurses. Strong antiseptics caused her to have a rash on her hands and Dr. Halsted introduced rubber gloves in surgery to help protect the delicate hands of his girlfriend. He then recognized that what was good for the goose was also good for the gander.

Early in this century the Flexner report did much to upgrade medical education. Medical schools that did not meet Class A standards were closed. The quality of the medical students improved considerably, but the quality of life for medical students left much to be desired. Many schools had a compulsory flunk rate. A friend of mine was told when he entered Tulane University in 1938 that 50% of the students would be failed during the first two years, and 50% of the students were failed during the first two years. Those who made it through medical school graduated in 1942 and then entered the Armed Forces after a nine month internship. Thirty percent of the 50% who graduated were killed in action during World War II.

Failure and war, however, were not the only problems for medical students and young physicians. Tuberculosis was a common disease among medical students, interns, and residents. A physician that I know well told me that he developed tuberculosis during his residency. He was sent to a TB sanitorium in the mountains of upstate New York. The open air method of treatment of tuberculosis was then in vogue. He told me he was placed in a screened-in porch and given lots of fresh air. At times during the winter the temperature dropped to 40 degrees below zero and he would wake up in the morning with a foot of snow covering his blankets. Obviously many physicians and nurses in those sanitoriums never survived the treatment. Ten percent of my own medical school class developed tuberculosis either during medical school or shortly thereafter. One girl in my class died of tuberculosis at the end of the first year of medical school.

Internship implied a person would be interned in the hospital for a year. The interns lived, ate, and worked in the hospital for room and board and no salary. They really did not need "pocket money" for recreation as there was no time for recreation. Interns were expected to be on duty 24 hours a day, seven days a week. An intelligent young lady in my class at Johns Hopkins was accepted for the prestigious Osler Internship at Johns Hopkins. Another young lady from another medical school also was accepted the same year for an Osler Internship. The other young lady was married but her husband was interning at Duke University. She suggested to my classmate that they alternate weekends on call so that she would be able to fly down to Duke on Saturday afternoon to see her husband over the weekend. This meant that the intern on call carried an unusually heavy load. Residents on the Osler Service became quite upset with this arrangement and called the two lady interns in and told them that if they were not willing to give up a year of their life for medicine they should get out of the medical

profession. The residents themselves worked long hours and they had little patience with interns who could not work long hours. Most services had a pyramid system whereby only about one fourth the interns on the service were invited to stay on for residency, and eventually only one person per year would become Chief Resident for that service. This system produced a few superbly trained specialists who were the olympic stars in medicine. They were long distance runners who could survive on little sleep, little money and little recreation. However, the system did not provide the quantity of well trained physicians and surgeons to take care of the majority of the people in the United States.

Unfortunately there have been fashions or vogues in medicine as there have been in many other aspects of life. For many decades Medicine was preoccupied with the bowels because drugs had been developed that could either speed up or slow down the bowels. I was raised in such an era of medicine. My mother frequently gave us children prophylactic castor oil or milk of magnesia on Friday night so we would be healthy the following week and would not miss any school. If I swallowed a cat hair I would receive a laxative. I mentioned that my grandmother died as a result of this fashion in medicine. Many physicians ruptured appendices by prescribing laxatives. Many nurses were taught that the main emphasis in nursing care was to clean out the lower intestine daily. I well recall some years ago when I was the only neurosurgeon or neurologist in Pinellas County, and had been working very long hours and had very little time for my family. Finally an hour of freedom came and I took my wife to a restaurant on the Tampa side of Gandy Bridge. I told the medical exchange to call me at the restaurant only for emergencies. Then just as our steaks were being served, a waitress came in and stated that there was an urgent phone call for me. A special duty nurse on the other end of the line apologized for calling me but stated that she felt I would enjoy my dinner much more if I knew that a certain patient had just had a bowel movement. The patient was comatose with an inoperable brain tumor and was unable to appreciate the bowel movement but the nurse just had to share her good news with someone.

You have learned much during your three years in medical school at the University of South Florida. Most of what you have learned is true and will stand the test of time; however, I hope that you will not assume that everything was gospel. I well remember when I was in medical school that a now famous scientist lectured to our class on poliomyelitis. He showed us slides indicating virus activity in the olfactory tracts and explained that polio virus entered the brain through the olfactory nerves that extended into the nasopharynx. He stated that since the virus penetrated the nerves directly rather than going through the blood stream it would be impossible to ever develop a polio vaccine. Fortunately, what he taught was later proved to be false as it was discovered that the polio virus does indeed travel through the blood stream and it was possible to make the polio vaccine.

I have told you a great deal of what has been wrong with medicine in the past. I have told you that many patients would have done better without professional medical help. Dr. Oliver Wendell Holmes, poet and physician, stated in the last century: "If the whole materia medica as now used could be sunk to the bottom of the sea, it would be all the better for mankind, and all the worse for the fish." However, much good was done in the past and I am a living example of what can be done with good medical care. During the 1930's I went with my family on our yearly vacation to Dooley County, Georgia. Most of you have never heard of Dooley County but it is about 25 miles from Plains, Georgia. While playing in the woods an insect bit my right little finger. The wound became secondarily infected and I then developed an ulnar bursa infection which communicated with my radial bursa. I developed massive swelling of the entire right upper extremity and my arm became two to three times the normal size. I had lymphangitis with red streaks going up my arm and chills and fever developed. This was before any of the antibiotics had been discovered. In retrospect I probably had a beta hemolytic streptococcus infection and could have easily died of what then was commonly known as "blood poisoning," and medically as septicemia. My father took me to a general practitioner in a small town about the size of Plains. He opened my ulnar bursa under local anesthesia in his office and drained out a large pan full of pus. I mentioned to you earlier that Semmelweis died of an infected finger and fortunately my country physician had a better result than his city physician.

The Present

Let us look at medicine and medical education of the present. Much is known about the anatomy, physiology and biochemistry of the body. There are a variety of antibiotics that are effective in most bacterial infections. Viral infections have thus far

been resistant to most antibiotics but some chemicals such as amantadine have been developed which are antiviral. Anesthesia has been developed to the point where true anesthetic mortality is very low. Surgery is successfully performed on all the organs of the body and several organs can now be transplanted from one human to another. Maternal and infant mortality rates have been dramatically reduced in most nations. Preventive medicine has greatly increased life expectancy in every continent.

Medical schools now attract some of the most intelligent, emotionally stable, and best motivated students in our society. The quality of medical students now is better than it has ever been in the past and I doubt that the quality of the students can be improved upon in the future. We are already getting the best. It is recognized that all medical students are not cut out of the same pattern and that each medical student not only has different fingerprints but also different intellectual and emotional talents. Students enter medical school with many different majors and many different backgrounds. There are three, four, and five year programs in various medical schools. None of these programs are ideal for all types of medical students. The problem is to pick the medical students who would do best with a particular type of program. It is impossible to teach students in three, four or five years all that is known about medicine so there has been considerable revision of the curriculum in most medical schools trying to achieve the best balance.

As you know there are now three medical schools in the state of Florida. Each school is unique. The University of South Florida College of Medicine has made fantastic progress in the short period of time it has been in existence. I would like to pay tribute today to the genius of Dr. Donn L. Smith who was the master architect for this medical center. He combined Art and Science in an efficient, functionally beautiful manner. We all owe Dr. Smith a debt of gratitude.

I felt somewhat ill at ease when I approached internship and realized that the decisions I made during the internship would affect the health and lives of many people and I realized how much medicine I did not know. This is a normal emotional reaction for those who are awarded the M.D. degree. I would like to reassure the graduates that you are well prepared to enter your residency training programs. Your colleagues in the medical profession will be happy to help you when you do need help. You will work long hours and many of you will experience fatigue. The work week in general has been reduced from over 120 hours to about an average of 80 hours. You will have an occasional evening off and an occasional weekend off. You will not become wealthy on your salary but salaries are considerably more than room and board. Our daughter's income has been over $16,000 at the St. Vincent's Hospital in New York in her first year out of medical school. Many people think of the past as "the good old days" in regards to medicine and medical education. These are the good days in the present.

The Future

Now let's look into the future. Chemotherapy of viral diseases will become more specific and more effective. Chemotherapy of cancer will also become much more effective. Microsurgery will extend the frontiers of surgery to smaller and smaller structures and synthetic materials will be developed which will be better tolerated by the human body. More and more joints will be replaced and more and smaller, badly diseased blood vessels will be replaced. An effective, efficient artificial heart will be developed and will replace heart transplants. People will not only have more quantity to life but also more quality to life. The aging process will be retarded but will not be eliminated.

What does the future hold for medical education? How can education in general and medical education in particular be more efficient? Students at all levels of education should be permitted to advance at their own pace. Many students could complete elementary school in less than six years. The senior year in high school is less important academically and yet is very important emotionally and socially to many students. However, I will predict that more and more students will be going to college after completing the junior year of high school. The senior year of college is also less important for medicine than the other three years; however, as I indicated to you previously I feel that it is very important to have a variety of programs for students of different backgrounds and different interests.

Much has been said about the maldistribution of physicians. Actually physicians now are pretty well distributed according to the population. Most rural areas and small towns are not far from hospitals and patients can usually be transported quickly over interstate highways or even by planes. However, it is likely that physicians will disperse to small towns. Medical care for those who dwell in the ghettos will create more of a problem. The solutions

are not simple. I have a friend who practiced in a marginal area and he was stabbed in the chest when he opened the back door of his office and on another occasion a patient's relative pulled a gun on him and forced him to change an insurance form. It is not going to be possible to get many physicians and nurses in ghetto clinics and medical offices until the ghettos can be made reasonably safe.

Much has been written and said about the socio-economic of medicine. Talk of National Health Insurance probably has created more hypertension in physicians than salt. I suspect that there will be National Compulsory Catastrophic Health Insurance. I personally would not oppose such a plan as I feel that one of the functions of government is to help citizens out in catastrophic situations. This actually is not a new concept but a concept thousands of years old. Leper colonies were created to care for lepers. TB sanitoriums were created by the state to care for those with tuberculosis. One might argue that these colonies and hospitals were establishd to segregate these patients from society. However, psychotic patients also have been cared for by the state even though it was recognized that psychosis is not an infectious disease, although it is certainly a catastrophic illness. It has been the proper function of government to help the victims of earthquakes, tidal waves, and hurricanes. These are catastrophic situations and illness and accidents at times are also catastrophic.

However, I do not feel that people should ask government to do for them what they are better able to do for themselves. The least expensive food that a person can buy is usually purchased directly from a farmer. The more middle men there are between the farmer and the consumer the higher the price of the food. Likewise in medical care the least expensive medical care is the care purchased directly from the provider. The more middle men there are in between, including governmental employees, the more expensive the care will be. I feel that taxpayers could not afford the cost of Comprehensive National Health Insurance which would be administered by the federal government.

I hope all of you are developing a philosophy of life which will sustain you for the years that lie ahead. It is actually more difficult to do philosophy transplants than heart transplants or kidney transplants. Philosophy must be something that develops within your own brains. Two members of my own medical school class later committed suicide and unfortunately suicide is not uncommon in the medical profession. With the proper philosophy you can find medicine immensely satisfying. An example might illustrate my point. A little over two years after I graduated from medical school I was an assistant resident in surgery at the University of Michigan Medical Center. I was rotating through thoracic surgery and was preparing to do a thoracentesis one Saturday night when a nurse interrupted me for an urgent telephone call. My wife tearfully informed me that I had just received orders that I was being called to active duty in the Naval Reserve and was to report to Fort Sam Houston, Texas, the following Thursday in uniform. The Navy was loaning me to the Army. When I arrived at Fort Sam Houston I was told that the Army might find it necessary to send a few of the unmarried Naval Officers to Korea. I breathed a sigh of relief as my wife had just given birth to our first child two months previously. I was told that the Army was very interested in those medical officers who had had training in research, and since I had had a National Research Council Fellowship in neurophysiology for a year at Johns Hopkins, I thought it was likely that I would be assigned to a research position at the Walter Reed Hospital in Washington, D. C.; however, when my orders came through I found that they had counted my year of operating upon rabbit brains as a year as surgical residency and that I was thus classified as a surgeon, and I was ordered to report to the Second Mobile Army Surgical Hospital. I was told that this particular MASH unit was "hot" and that I should make out a will and take out more life insurance. The medical officers were issued 45 caliber pistols and carbine rifles and when we first started operating in Korea we surgeons wore our 45's under our surgical gowns. There was some philosophical discussions as what we should do if our hospital was overrun by the enemy. We were the forward MASH unit and at times were rather close to the enemy. If our hospital was overrun by the enemy, should a surgeon abandon his patient and flee, should he pull out his 45 and fight, should he pull out his 45 and help protect the nurses from being raped, or should he continue operating upon his patient? Unfortunately, such discussions do not lend themselves to seminars and philosophy. I don't remember when it was that I stopped carrying my 45 to the operating tent. Actually five of the six surgeons in our MASH unit made the same decision. We each had made our own decision that our primary responsibility was to the patient. Our working day was 36 hours of assembly line surgery and I am not ashamed of the fact that I frequently fell asleep while operating. We not only did sponge counts but also fly counts

as there were usually many flies around the intestines when we did laparotomies. It was always reassuring to have the same fly count after the peritoneum was closed as we had when the peritoneum was open. There was a machine gun nest only about 20 feet from where I slept but I had no problems with insomnia. I knew that there were a lot better surgeons in the world than I was, but I was there and most of them were not. I had the responsibility and the only way that I could live with my own brain was to accept the responsibility and do the best that I could under the circumstances. I saw many horrible things in Korea and yet I have never had any war nightmares. I got two battle stars for being there but I never got the Bronze Star, Silver Star, or the Navy Cross. I did not get them because I didn't deserve them. I had done nothing extraordinary. I had only done my duty. I had developed a philosophy of life that I could either live with or die with. I hope that your own experiences in the next few years will convince you that you must live happily with your own brains.

I sincerely hope that someday you will look down on me. Physically this will not be difficult as I am not very tall. However, I hope intellectually you also will look down on me. If you do not I will have been a failure as a teacher. The Indians in Florida had a practice of building mounds. Each generation added to the mound and each generation could climb a little higher and see a little further. We in medicine must build our own mound and your generation of physicians must be able to climb higher and look further than my generation of physicians. I closed one of my lectures to you with the following story and I would like to share it with you again. The nervous system consists of a marvelous computer and many cables carrying information to and from the computer. Telephone repairmen do a reasonably good job repairing cables, but those of us in the neurological field are frequently frustrated because in many parts of the nervous system cable repairs have not been successful. I will always remember a medical meeting that I attended seven years ago and heard a British neurosurgeon, Mr. Walpole Lewin, present a paper, "Towards a Visual Prosthesis." Mr. Lewin realized that the eyes are merely television cameras and that the optic nerves and optic tracts are merely television cables. He realized that the television screen was actually in the back of the brain and that we now should be able to bypass the eyeballs, optic nerves, and optic tracts. He devised a small television camera which a person could wear on a skull cap and then fashioned small cables to carry the electrical impulses to the back of the head. He constructed a small transmitter to transmit the impulses across the intact scalp and devised a receiver to pick up these impulses and relay them to a stimulator placed over the visual cortex or television screen. Obviously amplifiers also were used. After much work he was finally ready to implant the unit in a human being. He implanted the unit in a lady who had been blind for many years. He then placed her in a dark room and turned on a light and asked her what she saw. She replied, "I see a star." Out of the pitch blackness she finally had seen a star and again had hope. However, she was able to see a star only because Mr. Lewin had seen a star earlier and had followed that star in spite of many trials and frustrations. Wise men have seen and followed a star for thousands of years.

The practice of medicine can best be described by a song in the "Man of LaMancha."

To dream the impossible dream,
To fight the unbeatable foe,
To bear with unbearable sorrow
To run where the brave dare not go.

To right the unrightable wrong,
To love, pure and chaste from afar,
To try, when your arms are too weary,
To reach the unreachable star!

This is my quest, to follow that star,
No matter how hopeless, no matter how far,
To fight for the right without question or pause,
To be willing to march into hell
for a heavenly cause,

And I know, if I'll only be true to this
glorious quest,
That my heart will lie peaceful and calm
when I'm laid to my rest.

And the world will be better for this,
That one man, scorned and covered with scars,
Still strove, with his last ounce of courage,
To reach the unreachable star!

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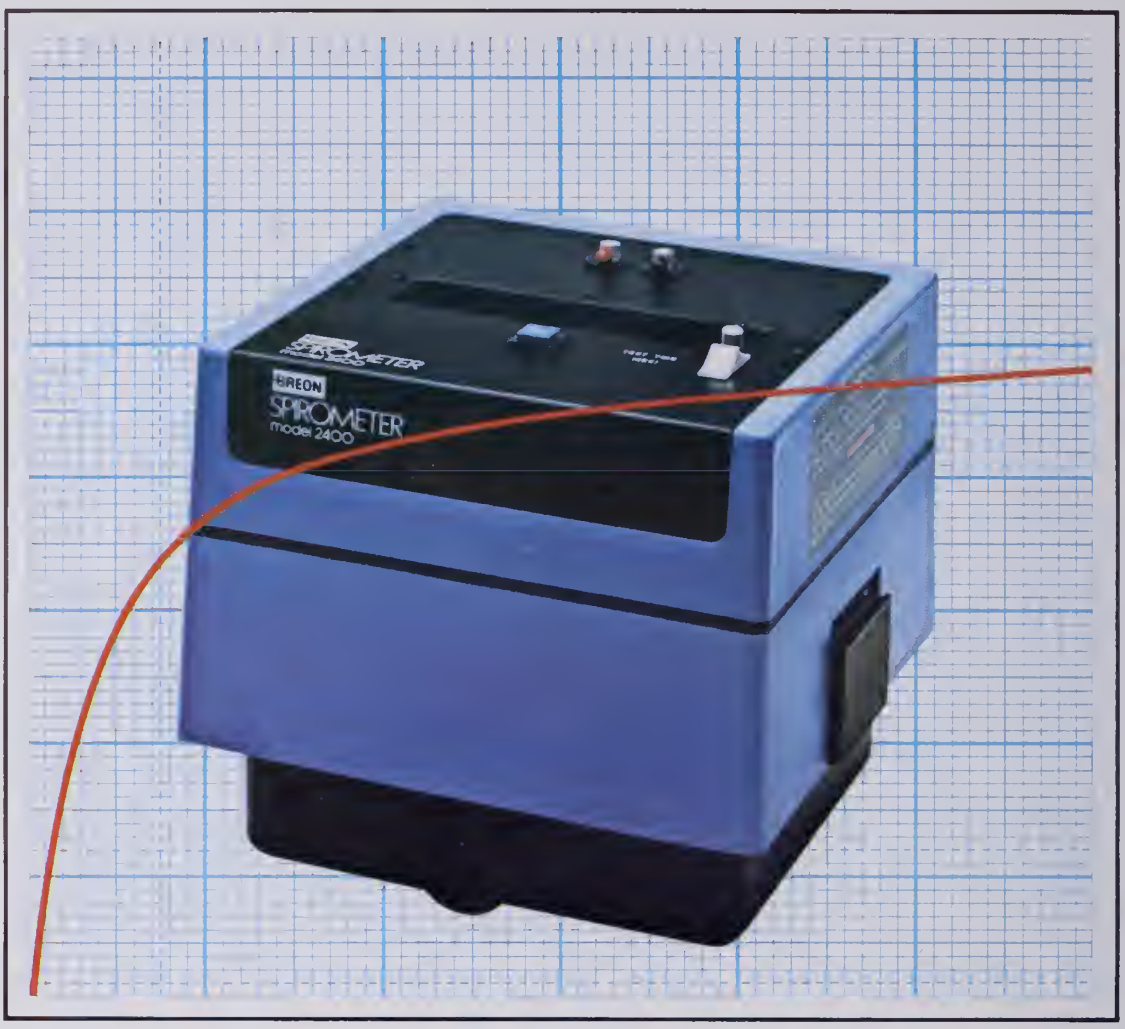
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EDITORIALS

May We Take Your Pulse?

How do you like your **Journal of the Florida Medical Association?**

Where does it stand among the many scientific publications you receive regularly?

What can be done by the Editors and the Staff of **The Journal** to make it more useful for you?

Elsewhere in this issue of **The Journal** is a readership questionnaire by which we hope to get your answers to these and other questions.

In the course of their travels to various county medical societies, the Editors of **The Journal** have been particularly attentive to the comments of physicians throughout Florida — both pro and con — regarding your publication. Assimilation of these comments has given us some concept on where we stand; but it still remains a subjective analysis.

Most magazines survey their readership once in a while to determine whether or not they are really meeting the readers' needs and expectations.

Thus, for the first time in several years, this issue of **The Journal** contains the "1978 JFMA Readership Survey." Experience tells us that only a small percentage of our readers are likely to take the few minutes necessary to answer the questions and mail the survey back to us.

We have made the procedure as expeditious as possible. This particular questionnaire should be completed within five minutes. After completing, simply tear the page out along the perforated edge, fold twice so that the JFMA address and the postal indicia show, and staple or tape closed. No postage is necessary.

Please tell us as you see it. We want an accurate pulse!

(See page 118a)

The Editor

News for Madison Avenue

Although scores of medical journals compete for the busy doctor's attention, a recent survey indicates state medical journals are at least holding their own in the pecking order.

The study involved 10 state journals and was conducted by Health Industries Research of Darien, Conn.

"State journals are extremely well read," HIR stated. "An average state journal is read by 79% of its audience each issue and 96% read at least one of four issues."

Reading patterns vary from journal to journal, HIR discovered, but most readers either peruse articles of interest and scan the remaining pages, or they read the table of contents and articles of interest only.

On the average, readers spend about a half-hour with a state journal.

The survey encompassed the state journals of Arizona, Connecticut, Indiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, and Texas.

Sixty per cent of the physicians responding in those states said they pay attention to journal advertisements regularly or occasionally.

Madison Avenue, take note!

The Name of the Game

How often does one hear the comment, "why didn't I know that?" How frequently does one also hear the retort, "you were told that, you just didn't listen!"

We all know how important it is to communicate effectively with each other, regardless of the topic. Within the Florida Medical Association, communications are transmitted daily, still, how much does the physician really receive? Just like a chain, no matter how effective the communication might have been, a break at any point will negate the entire communique.

FMA Priorities 1977-78

". . .Continue and intensify the informational program for county medical societies and the membership . . . Improve liaison and coordination with county medical society officers and staffs, and specialty groups . . . Branch offices in South and Central Florida . . . Further implementation of FMA Public Relations Program for members and the general public . . ."

The FMA has an excellent communications network from the Jacksonville headquarters to each county society. Information is passed back and forth each day from throughout our state to provide each segment of our entire organization the appropriate information that will allow the membership to be up-to-date with the ever-changing role of medicine in our society. From the local society organization, communications are transferred back and forth between individual members; therefore, every physician should be able to receive an answer to a particular query.

Like any organization with over 10,000 members, the efficiency of the entire operation is dependent upon the integrity of the system throughout its network. A vital link in the total FMA structure is the executive staff of the larger county societies. Individuals serving in such a capacity must be uniquely qualified to understand the many challenges related to physicians and the role of medicine in the community. The executives of such county societies can benefit greatly by sharing their experiences with their counterparts in other societies. Periodic meetings to discuss mutual problems should also be of value. Having representatives from the state's executive staff at such meetings would also provide an opportunity to reinforce the liaison throughout the network.

As FMA membership continues to grow, the Executive Committee and Board of Governors have directed the executive staff to establish two regional offices, one in Dade County and the other in Tampa. This step will be implemented to further improve the liaison between the state office and the various component societies. The expertise of such staff will be available to the members of each local society within that region. This reorganization of the FMA resulted from the long term planning of your leadership with the express intention of continually providing the most up-to-date and relevant information that would benefit all members.

As physicians, we must remember our obligation to inform the general public about health matters which concern them. In turn, we should present to the public information regarding the services offered by physicians throughout Florida. This can be performed effectively through the various media such as the newspapers, periodicals, radio and television. Any physician who commits himself to being involved in such an effort will find representatives of each media discipline willing to work with organized medicine, eager to make every effort to transmit to the public the information that we desire. Some county societies have ongoing television programs which provide an excellent vehicle for information that improves the public's knowledge of health matters. The amount of information available encompasses a wide spectrum when one considers the multiple specialties of medicine. Each have outstanding individuals capable of serving in public relations efforts. Such physicians will have the satisfaction of knowing that they are contributing toward a better understanding by the public of the complexities of health services and health care delivery. Through such public relations involvement we foresee the evolution of greater public support of our efforts. We must continually re-emphasize that physicians are deeply concerned about the welfare of each citizen.

How important it is to enhance such participation in every community, to let every citizen know that the profession of medicine is his friend. Those

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Editor's Note: The above editorial is another in a series **The Journal** is publishing on FMA's priorities for 1977-78.

communities who have active public relations programs find continuing enthusiasm by the public who read or view the material presented. What greater ally could organized medicine have than the participation of an informed citizen who becomes an active supporter of our programs. Such involvement, in turn, adds strength to our total effort. This pattern over the years has worked quite dramatically in the voluntary health agencies. In these, dedicated and concerned citizens have worked actively to promote many different kinds of involvement in concert with the leadership of organized medicine.

Yes, the name of the game is communications. However, like any other game it must be played with each individual member providing his total support and contribution to such an effort. Our FMA leadership is working diligently in every way possible to see that each physician member is well informed. Don't let the chain of communication have its faulty link at the recipient end. If you, as a member physician, do your part, then you will never have to ask the question, "why didn't I know that?"—Robert E. Windom, M.D., Secretary, Florida Medical Association, Inc.

The Arthritic's Lament

I know now why I have this pain,
My joints are badly all inflammed.

But when I move they start to creak,
And soon the pain begins to peak.

I quickly stop the motion then,
So that the pain will promptly end.

I dream of days when joints were clear,
And rheumatism was not to fear.

My life was good in days gone past,
For I could walk so very fast.

My body joints were free to use,
They were not bound or badly fused.

I hope that God will hear my plea,
And take away this curse from me.

Perry A. Sperber, M.D.
South Daytona Beach

Dr. Sperber is retired from the specialty of Dermatology.

Impact of the Tax Reform Act of 1976 on Your Tax-Qualified Retirement Plans

Howard G. Dunlap

The Tax Reform Act of 1976 (TRA) significantly changed the way estates and gifts are taxed. It also changed the application of income and estate tax law to tax-qualified retirement plans.

Ten Year Averaging for Lump Sum Distributions

When you are ready to retire, you have to choose basically whether to receive funds in your retirement plan as income or as a single payment. If you choose income, each payment will be taxed on ordinary income except, of course, to the extent you contribute to the plan from your after-tax income. This has not been changed by the TRA. If you choose single payment, the law permits taxing the entire amount according to a ten year averaging formula first introduced on a limited basis by the Employees Retirement Income Security Act of 1974. Ten year averaging is available only to lump sum distributions from corporate retirement plans and HR-10 plans.

Ten year averaging works as follows: Divide the total distribution by 10. Look up the single taxpayer's income tax rate for the resulting figure as if it were annual income and multiply that tax by 10. The result is the total tax due. An especially valuable feature is that the tax due is computed in complete isolation from your other income.

If the lump sum exceeds $320,000, the excess will be taxed at a rate of 50%. In view of this, a point will be reached, usually somewhere between $320,000 and $500,000 depending upon age and other circumstances, at which the tax treatment probably will be more favorable if you take the distribution as income rather than a lump sum. Fortunately, as long as your retirement plan trust agreement provides sufficient flexibility in the election of distribution, this decision need not be made until the time of distribution.

As a result of the TRA, taxable distribution from retirement plans are now classified as "earned income." As such, they cannot be taxed at a rate in excess of 50%. Under prior law, retirement plan distributions were classified as unearned income and could be taxed at a maximum rate of 70%.

Estate Tax Exclusion for Proceeds from All Retirement Plans

In the area of federal estate taxation, the TRA remedied a glaring inequity between the tax treatment of corporate retirement plans and HR-10 plans. The Act extended the federal estate tax exclusion to proceeds from HR-10 plans and Individual Retirement Accounts (IRA). If a participant in an HR-10 plan or IRA plan dies before retirement, the funds in his retirement account can be paid to his beneficiaries without being included in his estate for federal estate tax purposes. The participant must have designated beneficiaries other than his estate.

This article was submitted by the Florida Medical Association's Council on Medical Economics, James F. Richards Jr. M.D., Orlando, Chairman.

Mr. Dunlap is an associate with Gordon Rainey and Associates representing New England Life Insurance Company in Jacksonville.

Estate Tax Inclusion for Lump Sum Distribution

If a participant dies before his plan accumulation has been distributed to him, the accumulation will go to his heirs. If he designated a beneficiary other than his estate, the accumulation should pass to that beneficiary exempt from federal estate tax. We might assume that if the accumulation was distributed to the beneficiary as a lump sum payment the income tax break of ten year averaging would also be available — in other words, no estate tax and only minimal income tax.

The TRA stipulates that if a distribution to the beneficiary of a deceased participant qualifies for the ten year averaging formula, i.e., lump sum distribution, the estate tax exemption is forfeited. In other words your heirs cannot have both tax breaks. If it is lump sum distribution to a beneficiary, qualifying thereby for the income tax break of ten year averaging, the estate tax exclusion is not available. The estate tax exclusion continues to be available where the proceeds are payable to a designated beneficiary in some form other than lump sum payment. Then, however, the income tax advantage of ten year averaging is lost.

This complicates estate planning decisions regarding retirement plans. With careful planning it should be possible to arrange matters so that crucial decisions as to how to distribute retirement plan funds to your heirs can be made by a trustee or successor trustee at the time of distribution. But one decision must be made in advance: a beneficiary other than your estate must be selected during your lifetime if you want the estate tax exclusion.

Summary

At retirement you will have to decide whether to receive the accumulated funds as income or as lump sum payment. If you choose income, each payment will be taxed as ordinary income. If you choose lump sum payment, you may compute the tax by using the ten year averaging formula. All other income may be excluded from this computation. Whether you choose income or lump sum, the income tax rate cannot exceed 50%. If you should die before retirement, the same income tax provisions apply to the beneficiary.

The federal estate tax, if any, due on your retirement plan accumulation should you die before retirement will depend upon two things. If you named a beneficiary other than your estate, the accumulation can pass to that beneficiary exempt from federal estate tax. If it passes to the beneficiary as a lump sum, the estate tax exemption is lost.

For the most part the TRA further strengthens the tax advantages of qualified retirement plans. Such plans continue to be the soundest way to defer and diminish taxes on current earnings. The changes in the new law are too complex to cover totally in a short article and require the attention of your attorney or other tax advisers.

Important Notice to Authors

In view of The Copyright Revision Act of 1976, effective immediately, all transmittal letters to the editor must contain the following language before manuscripts can be accepted for possible publication:

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This statement must be signed by the principal author and all co-authors.



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Commentary

An Overall View of State Medical Journals

Highlights from an address by Pearl Mead, Medical Director for William Douglas McAdams, Inc. Advertising Agency. This address was delivered at the 1977 National Educational Conference and Workshop of the State Medical Journal Advertising Bureau, September 18, 1977 in New Orleans.

In discussing the specific values of state journals, Ms. Mead delves into the whys and wherefores of their value to the pharmaceutical industry.

Before deciding where to put their advertising dollars, the industry asks the following questions: In which area of the country does the most prescribing of specific drugs take place? Why promote drugs in certain sections in preference to others? How can promotion be most effective?

Dividing the country in four major areas, a National Disease Therapeutic Index yields statistics that medications generally are most widely used in the south. The east accounts for 40% of all prescriptions for allergens but the south accounts for 32% of all prescriptions for fungicides. Among antibiotics, Amoxicillin sales in the south are 45% of the total used throughout the country and, surprisingly, of the total use of Rondomycin in this country, the south accounts for 72%.

The pharmaceutical industry, wanting to distribute their advertising dollars where they will bring the best returns, must weigh the merits of a black and white page that costs $2,720 in the Journal of the American Medical Association, with the same ad costing $3,531 in 33 state journals and will cover only approximately two thirds of the nation.

State medical journals achieve their objectives in advertising values for the advertisers by serving as an aid to the testing of products and to bolster regional programs where sales are not very strong. They are excellent for use in promoting seasonal products and are of great value in addressing regional audiences with regional problems. Special interest projects may be promoted in state journals when a regionally-oriented product can best be promoted regionally.

Advertising is placed in state journals because readership is considered high, and editorials of local interest are provided. Individual physicians are involved. They know the people and keep up on social events, welfare of the people in the area and other interesting items, plus providing local medical news. As the quality of the editorial standards of the journals varies throughout the country, some being more successful editorially than others, all are urged to strive to be consistently higher in quality, for by doing so, they will become more desirable as advertising media.

As marketing of products becomes more difficult, one positive feature in favor of individual state journal advertising is the Special Issue which attempts keying in on certain types of physicians, making it easier to reach specific segments of the market.

It is to be hoped that this analysis will help all understand better the variety, diversification, problems—and basically, the importance of a common interest—that of advertising in the state medical journals. The outlook for the future is in the continued growth of these journals. For the busy physician, the printed page will always be the best way to reach him. To advance the cause of medical journals, a cooperative spirit of exchange between the journals and advertisers will provide the greatest good for the largest number.

C.M.C.

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ADMINISTRATOR-FMA INSURANCE PLANS

ADMINISTRATOR

CLOSED CLAIMS SURVEY AND ADVISORY NO. 3

Since the last advisory letter in November, 1977, the following claims have been settled on behalf of the FMA-PLI-Trust and the Florida Physicians' Insurance Reciprocal. These claims are discussed under specialty headings.

FAMILY PRACTICE

Delay in diagnosis of cancer of a tonsil. After three office visits, the patient consulted another physician who biopsied a chronic ulcer of a tonsil and diagnosed cancer. The allegation was that the delay in diagnosis caused the condition to worsen.

NEUROLOGY

Patient fell during a Rhomberg test. This stroke patient sustained a rib fracture as a result of the fall. The physician should have had an assistant who would be ready to catch this unstable patient.

OBSTETRICS - GYNECOLOGY

Two unsuccessful D&C's. The patient was later admitted to the hospital with an incomplete septic abortion. An 11 cm fetus was removed during the third procedure.

Missed pregnancy. A D&C was performed for amenorrhea. This patient of child-bearing age was on birth control pills. A D&C was done without a test for pregnancy, and patient was pregnant. The first D&C was incomplete, and a second one was necessary.

PEDIATRICS

Lack of instructions produced burns. The patient's parent mentioned to the physician that her child had white spots (vitiligo) and received a prescription for a lotion (Oxsoralen) without any instructions as to avoidance of exposure to sunlight. After the lotion was applied, the child went to the beach and sustained second- and third-degree burns which resulted in hospitalization and serious scarring. Defense of the claim was complicated by the fact that the physician had never seen or examined the patient. "Sidewalk consultations" are dangerous!

SURGERY

Foreign body left in abdomen. Patient had extensive abdominal surgery. The physician received a "normal" sponge count on closing. One year later, a lap pack was discovered by X-ray. This is the fourth claim for a sponge or lap pack left in the abdomen during the past two years. Fortunately, losses have been minimal because of good physician-patient relationships.

February, 1978

ORGANIZATION

Annual Meeting Program Approved For Category I Credit

The Medical Education Committee of the Florida Medical Foundation has agreed to co-sponsor the 104th Annual Meeting of the Florida Medical Association and certify its scientific program for AMA Category I Credit.

The Committee, as an "accredited co-sponsor," approved the program for hour-for-hour credit up to 20 hours, according to Robert H. Threlkel, M.D., of Jacksonville, Chairman of the Committee.

Category I Credit is required for the American Medical Association Physician's Recognition Award and may be reported as Mandatory Credit under the FMA CME program for members.

The 104th Annual Meeting will be held at the Diplomat Hotel in Hollywood, May 3-7. The following scientific section programs are in addition to those published in the January issue of *The Journal*.

SECTION ON FAMILY PRACTICE
(Co-sponsored by Florida Academy of Family Physicians)
Friday — 1:30 p.m. to 5:30 p.m.
E. Frank Ciliberto, M.D., Tampa
Program Chairman

Welcome — Dick L. VanEldik, M.D., President, Florida Academy of Family Physicians.

"The Gerontocracy: Sociodemographic Aspects of the Aging Population," E. Frank Ciliberto, M.D., Assistant Professor of Family Medicine, University of South Florida College of Medicine, Tampa.

"Biologic Aspects of Aging," Alfred Laughton, M.D., Ph.D., Ridge Manor, Florida.

"Psychologic Aspects of Aging," Jack Skigen, M.D., Clinical Assistant Professor of Psychiatry, University of Miami School of Medicine, Miami.

Questions and Answers/Panel
Moderator:
Henry L. Harrell Sr., M.D., Ocala
Panelists:
E. Frank Ciliberto, M.D.
Jack Skigen, M.D.
Alfred Laughton, M.D., Ph.D.

Selected Topics — Presentations by Residents from the University of South Florida, College of Medicine, Department of Family Medicine Affiliated Residency Programs
Responder Panel to Resident Presentations
Adjournment

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY
(Co-sponsored by Florida Society of Plastic and Reconstructive Surgery)
Saturday — 9:00 a.m. to 12:00 noon
S. Anthony Wolfe, M.D., Miami
Program Chairman

"Recent Advances in Craniofacial Reconstruction," Mutaz B. Habal, M.D., Associate Professor of Plastic and Reconstructive Surgery, University of Florida College of Medicine, Gainesville.

"Some Problem Cases in Facial Reconstruction and Their Solution," Residents from the Department of Plastic and Reconstructive Surgery, University of Florida College of Medicine, Gainesville.

"A Potpourri of Hard-Tissue Plastic Surgery," S. Anthony Wolfe, M.D., Miami.

"Recent Advances in Breast Reconstruction," Residents from the Department of Plastic Surgery, University of Miami School of Medicine, Miami.

"Early Transplant Surgeons," Felix Freshwater, M.D., Miami.

Adjournment

Standard Medicaid Form Sought by FMA

The Florida Medical Association, Inc., filed suit in December to prevent the Florida Department of Health and Rehabilitative Services from using a new claim form for physician and pharmacist Medicaid services.

FMA was granted a temporary restraining order, but Circuit Court Judge James Joanos of Tallahassee reversed the order the following week.

FMA contended that the Department of HRS failed to abide by a Florida law directing that a standard claim form be used for Medicaid by all physicians and pharmacists; and that use of the HRS form would increase the cost of care for Medicaid patients whose physicians use a cost efficiency data processing system.

The proposed form does not conform to any electronic data processing system in the state or computer format now being utilized by health care providers in processing health care claims for patients.

Meanwhile, the Florida Insurance Department issued a directive delaying until July 1, 1978, the deadline for use of new claims forms. HRS officials have offered to work with FMA in developing a suitable form.

Summary of the FMA Board of Governors Meeting January 14, 1978

The following is a summary of the actions taken by the Board of Governors at its meeting on January 14, 1978.

THE BOARD:

1978 CALLED MEETING CANCELLED

Cancelled the Called Meeting of the FMA House of Delegates scheduled to be held February 4-5, due to a lack of a quorum of delegates.

EDITOR FMA JOURNAL

Unanimously approved the President-Elect's selection of Gerold L. Schiebler, M.D. for reappointment as Editor of the FMA Journal for 1978-1979.

COST OF MEDICAL CARE COMMITTEE

Approved creation of a state level committee on the cost of medical care to be comprised of representatives from the FMA, Florida Hospital Assn., Blue Cross and Blue Shield, The Health Insurance Council, and Industry, for the purpose of conducting an indepth study of the factors affecting the cost of medical care, and to encourage individual representatives to seek ways of resolving these problems within their individual sectors.

JUA

Adopted a position that the FMA not oppose continuance of the JUA on a three year self-destruct basis.

DEFINITION OF PUBLIC HEALTH

Adopted the following definition of public health:

"Public health is a science and art of applying knowledge and skills from medical and allied sciences in an organized community effort to maintain and improve the health of groups of individuals."

FMA INJUNCTIVE ACTIONS

Authorized the FMA to seek injunctive relief against any governmental agency which acts in violation of the law and which acts jeopardize physicians.

EMS CONFERENCE

Approved FMA cosponsorship of a statewide EMS Medical Directors Conference. The purpose of the conference is to provide EMS directors with a good understanding of their responsibilities and liabilities under the EMS act adopted during the 1977 session of the Florida legislature.

CONFERENCE ON GERONTOLOGY

Approved FMA cosponsorship of the 27th Annual Southern Conference on Gerontology to be held in Gainesville, March 28-31. The theme of the Conference is "Back to Basics" and will involve the issues of nutrition and shelter for the elderly.

FLORIDA PSYCHIATRIC SOCIETY RESOLUTION

Expressed support for the resolution adopted by the Florida Psychiatric Society regarding the state's mental health hospitals, the resolve of which brings to the attention of the public, the legislature and the Governor the substandard management and care rendered in the state's mental health hospital programs, and urges elevation of care to an acceptable level, including obtaining the medically trained personnel to direct and supervise state mental health hospital programs.

COUNCILS AND COMMITTEES

COMMITTEE ON ALLIED HEALTH PROFESSIONS

Nurse Practice Act — Received a report on a meeting held between representatives of the FMA, the State Board of Medical Examiners, Florida Nurses Association, and the State Board of Nursing, regarding promulgation of rules and regulations for the 1975 Nurse Practice Act. As a result of the conference, it was agreed to reconvene the joint advisory committee established by the act for the purpose of defining additional functions for advanced nurse practitioners.

COMMITTEE ON HSA'S

Guidelines — Approved guidelines under which the FMA Committee on HSA's will function which will include:

Close scrutiny of state and federal regulations affecting HSA's, particularly health planning guidelines.

Certificate of need — Assist in establishment of local physician committees for the purpose of receiving and forwarding activities of local HSA's.

When appropriate, maintain liaison with FMA recognized specialty groups regarding HSA activities.

Regional meetings — Urged Florida's U. S. Congressional delegation to monitor HSA regional meetings in order to view first hand the inherent failures of Public Law 93-641.

COUNCIL ON LEGISLATION AND REGULATIONS

Adopted the following positions regarding legislation to be considered by the 1978 session of the Florida legislature:

Endorsed legislation which would eliminate duplicate inspections of hospitals by local, state and federal entities.

Support legislation (HB 118) which would prohibit use of prescription drugs by optometrists.

Actively oppose legislation (HB 419) which would abolish mediation panels.

Opposed legislation to license acupuncturists in Florida.

Authorized development of implementing legislation for a constitutional Department of Health.

COUNCIL ON MEDICAL SYSTEMS

Indigent health care — Adopted a statement on health care for the indigent embodying standards for:

- Delivery of health care for the indigent;
- The efficient administration of Florida's Medicaid program;
- Realistic funding and accountability for expenditures.

FLORIDA HEALTH DATA CORPORATION

Received a report from the Florida Health Data Corporation regarding a pilot project involving selected Florida hospitals for collecting health data. This is part of the joint effort by the Florida Medical Association, Florida Hospital Association, and the Florida Osteopathic Medical Association, to establish and operate an independent health data bank which is accurate, timely, and comprehensive, and which is controlled by the private sector.

COUNCIL ON MEDICAL ECONOMICS

Cost of medical care — Encouraged hospitals to post at nurses stations the cost of the 15-20 most common procedures to educate physicians as to the cost of procedures most commonly ordered.

PMUR — Approved implementation of strong peer medical utilization review in relation to inpatient care regardless of the involvement of third parties.

BLUE SHIELD

Endorsed Blue Shield's medical necessity project including further study of additional operative medical and diagnostic procedures that may be obsolete and inappropriate and which should be subject to disallowance.

COUNCIL ON SPECIALTY MEDICINE

Pap Smears — Supported the concept of a hospital based uterine cytology program to be on a voluntary basis as deemed appropriate by each hospital medical staff.

Lay-Midwifery — Expressed support for legislation which would prevent further licensure of lay-midwives.

Abortion Clinics — Proposed legislation to regulate abortion clinics in the state.

Dr. Thomas Thames Appointed To Reciprocal Board



Dr. Thames

Orlando family physician, Thomas B. Thames, M.D., has been elected as the fifth and newest member of the Florida Physician's Insurance Reciprocal, Board of Directors. Dr. Thames will serve a four-year term which will expire in December 1982.

A graduate of Duke University School of Medicine, Dr. Thames has long been active in organized medicine.

He is a member of the Executive Committee of the Board of Governors of the Florida Medical Association, and is past Chairman of the FMA Council of Medical Services. He is immediate Past President of the Florida Academy of Family Physicians; a member of the Board of Governors of Orlando Regional Medical Center; and serves as an alternate delegate from FMA to the American Medical Association. In 1970, he served as President of the Orange County Medical Society.

Dr. Thames is the Medical Director for Walt Disney World, Martin-Marietta Corporation, Coca Cola Company Foods Division, Sea World, and the Orlando Utilities Commission. He is also Associate Medical Director for National Standard Life Insurance Company, where he is a member of the Board of Directors.

O. William Davenport, M.D., President-Elect of the FMA has been reappointed for a five-year term, which will expire December 1983.

Other members of the Board of Directors of the Florida Physicians Insurance Reciprocal and the expiration date of their appointments are: Richard S. Hodes, M.D., whose term expires December 1979; Jack A. MaCris, M.D., December 1980; and Vernon B. Astler, M.D., December 1981.

AMA Plans Hospital Staff Leadership Conference in Miami Beach

The American Medical Association will sponsor four seminars in "Hospital Medical Staff Leadership" during 1978, including one in Florida.

The Eden Roc Hotel on Miami Beach will be the scene of the fourth seminar on November 3-4.

Information may be obtained from the Department of Hospitals and Health Facilities, American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.



Others Are Saying

National Health Plan: An Unnecessary Evil

WASHINGTON — In his press conference of October 27, President Carter said he couldn't think of any major innovative proposals he would offer in 1978 or 1979. Shortly thereafter, responding to some raised eyebrows, the press office said that wasn't exactly so.

Mr. Carter had not abandoned his promise of national health insurance. Such a program would yet be presented.

Maybe so. Mr. Carter's commitment was absolute. Time after time on the campaign trail, he pledged his efforts to enact a "comprehensive, mandatory program of national health insurance."

This is the kind of sweeping first-dollar, all-embracing program that Senator Edward Kennedy (D-Mass.) continues to push. The 100-member Committee for National Health Insurance still is beating the drums for this scheme.

The American Public Health Association, which met in Washington last week, raised whoops and hollers for "socialized medicine" as such.

But unless I am wholly mistaken, most of the steam has leaked out of the movement toward national health insurance. Victor Hugo once said that no army can resist the strength of an idea whose time has come.

By the same token, no army can impose an idea whose hour has passed. This idea is over the hill.

Several reasons support that cheerful prediction.

So radical a departure from existing patterns of medical care would have to command overwhelming popular support. Are the people clamoring for national health insurance?

Unless my ears deceive me, the people are as quiet as so many clams. Last year, NBC took a poll: "Do you favor or oppose a program of health insurance paid by the government through increased taxation?"

Only 36 per cent of the respondents said yes. Almost half opposed; 16 per cent were not sure. It is not what you would call a ground swell.

The NBC figures reflect the growing disillusionment with federal programs generally. What is proposed, under Kennedy's grandiose plan, is to turn medical care over to the same wonderful folks who have given us Amtrak and the Postal Service.

If ever a majority of the people believed government could perform a function better than the private sector, that belief no longer commands much support. People disenchanted with public education have no perceptible enthusiasm for comprehensive public health.

The opposition to the Carter-Kennedy program rests on more than intuitive antipathy. The people are perfectly capable of foreseeing fantastic costs, and they don't like what they see.

The senator's idea is to scrap all existing programs of private insurance; he would also abandon Medicare, and he would retain only parts of the health care now provided under Medicaid, the Veterans Administration, and other agencies.

In their place he would erect an enormous new bureaucratic structure headed by a Health Security Board. This board would effectively fix hospital budgets, fix doctors' fees, fix prescription prices, collect billions of dollars in new taxes, and disburse millions of checks annually to providers of health services.

The total cost? No one has even a foggy notion of the cost. Two hundred billion, three hundred billion? It is all the same to Messrs. Kennedy and Carter.

Present costs are vaguely estimated at $145 billion. Once all restraints were abandoned, the figure easily could double or treble.

Who would pay for all this? Who do you think would pay for this? The Kennedy-Carter plan envisions new taxes on employer and employee (on top of the stunning Social Security increases now in prospect), plus matching billions from the general fund.

There is no way under moon or sun that Mr. Carter could fold any such program into his budget for 1979 or 1980, and still hope to see the budget balanced.

An estimated 92 per cent of our people now are covered by some sort of health or hospital insurance. Relatively speaking, only a small minority of families have no coverage of sort.

The poor are fully covered by Medicaid, the aged by Medicare, the veterans and their families by military benefits. In our largest industries, such as automobile manufacturing, collective bargaining has resulted in health benefits equaling what Kennedy proposes.

If any federal program at all can be justified — and can be afforded — it is a program to insure the risk of catastrophic illness. If Mr. Carter will settle for that, few persons will belabor him for breaking a promise. And you can depend on that.

James J. Kilpatrick

Reprinted from the Florida Times-Union, Jacksonville, November 12, 1977.

Mr. Kilpatrick is a syndicated columnist (Copyright 1977, Washington Star Syndicate, Inc.)

Remember, nobody will ever get ahead of you as long as he is kicking you in the seat of the pants. — Walter Winchell

Cost, Quo Vadis

In 1957, the United States invested 4% of all its wealth produced in health care. Over the next 20 years, the figure has risen to 8%, resulting in what is referred to as "skirmishes around the nation over allocation of funds(1)."

Today, consumers, government, organized medicine and industry are engaged in separate analyses of costs of health. The importance of health care cost control is documented by repeated references to it in the nation's press (in particular reports of congressional activities), a keynote editorial in the March, 1977, Journal of the Florida Medical Association (2), a large scale study on cost effectiveness of treatment of streptococcal infection for prevention of rheumatic fever in the April, 1977, Annals of Internal Medicine (3), dedication of the major portion of the 1977 Annual Meeting of the American Society of Internal Medicine to discussion of distribution of health care dollars, a special article in the March 31, 1977, New England Journal on cost effectiveness (4), and a symposium dealing with quality of health care and cost at the American College of Physicians meeting in April, 1977.

All seem to agree on a single basic axiom, that no more than the current 8% of the nation's productivity can be invested in health. From that point, however, each takes a different approach to analysis of the problem. This suggests that at lest some of the confusion arises from failure to carefully define terms. For example, in these discussions, cost benefit is an expression of the value of a procedure to an entire population as a function of the amount of money spent, whereas cost effectiveness attempts to define how many dollars are necessary to assure that a goal is achieved, that is, obtaining better health for an individual is a function of the dollars spent (4).

Politicians seem more inclined to view cost benefits as the key measurement. Medicine appears, because of its humanism, to be more strongly oriented toward the latter approach, inclining to disregard statistical assessments of cost of health care for populations and instead concentrating on the effectiveness of spending more health dollars to obtain a more comfortable, more useful life for the individual recipient of care. Thus, in discussing a publication concerning cost benefits in management of streptococcal pharyngitis contained in the April, 1977 Annals of Internal Medicine, Dr. Robert Pantell points out that although the study might conceivably lead to savings by the population resulting from not treating individuals at low risk to pharyngitis, it would do so at the expense of a few patients who would develop rheumatic fever (5). Carried to its illogical extreme, this concept led to Dr. Lasagne's recent suggestion that empiric antibiotic treatment of all respiratory infections was a good practice because it resulted in a lower frequency of rheumatic fever (6).

That discussions of health care cost are necessary at all, is partly a consequence of a variety of pharmacologic and technologic changes which have occurred in medical practice in the past 20 years. Dr. E. J. Potchim, President of the Society of Nuclear Medicine, recently presented data on why doctors use x-rays (7). He categorized the reasons for x-ray orders in three classes: first, defensive ordering; second, innovation or curiosity; third, clinical efficacy. On the average, approximately 10% of x-ray studies are ordered simply out of curiosity (a lower figure than was quoted in the early 1960's), approximately 30% for defensive purposes and the remaining 60% because of clinical efficacy.

However, if one looks at different categories of physicians, one finds that their response to their particular situations leads to different levels of utilization. Thus, the physician in a community hospital fits very close to the national average in all areas with the only substantial difference being a slightly lower frequency of use of x-rays for legal defense. In the university hospital, more x-rays are devoted to innovation and defense than the average and in the emergency room, over 70% of all x-rays are ordered simply to prevent legal liability.

Another factor playing a large role in the advancing cost of medical care is the premature adoption of new techniques into medical practice, long before thay have been adequately analyzed. This is referred to as the so-called "fever curve of the new study," in which one can plot the number of times a new technique is used versus years and find that there is a rising frequency for the first two years and over the next three years, a declining frequency until, in most cases, the study is only done by those few individuals who pioneered it, having been abandoned by most other physicians.

This so-called fever curve applies very well to the technique of gastric freezing advocated in the early 1960's. Early enthusiasm for that expensive procedure was only dampened after several years of wide use demonstrated its negligible benefits.

Whether the fever curve will apply equally to the use of today's most avant garde technique, computerized axial tomography (CAT), remains to be seen. However, it remains clear that a large number of CAT studies are done, not because of their proven efficacy, but because there is a theoretical possibility that they might show something, that is, they are done for innovative or curiosity purposes, not because of demonstrated usefulness.

The reasons for early adoption of such techniques however include other factors such as, (1) an attempt by the physician to maintain patient rapport because of the patient's familiarity through the lay literature with new unproven techniques, (2) the premature developments of medical standards of care based upon community acceptance of procedures without proven benefit, (3) the adoption of use of a procedure because of a so-called "legal standard" of care which ultimately appears to threaten the physician who fails to incorporate these procedures into his practice.

Audit is another costly innovation in health care. It is proposed that audit, such as in PSRO, properly applied, will reduce cost and improve care. Several key questions raised by theory are being addressed. First of all, do technical or procedural advances (such as PSRO) increase the quality of care commensurate with their cost? Secondly, at what point does more money cease to yield better care, and third, how do we contain cost yet assure unfettered advances in care?

In an attempt to answer the first of these questions, the American College of Physicians has engaged in a study sponsored by the Kellogg Foundation to determine whether PSRO, while reducing cost, really does guarantee concurrent quality assurance (8). The net result of the study is that PSRO, although defining the level of quality care, does not in itself guarantee or promote such quality. Thus, the cost of PSRO is not associated with any measurable increase in quality of care. As a matter of fact, the presence of a residency training program in a

hospital seemed to yield better adherence to criteria established for quality care than did a PSRO program.

Although we are all aware of the vocal energy expended in governmental circles over cost of health care, perhaps we are not as familiar with some of the basic economic factors underlying this. It is now recognized, according to L. H. Buttler, former Assistant Secretary to Health in HEW (1969-1971), that over 40% of health care costs of the United States are paid by these agencies (9). In the federal budget, medical cost ranks only behind defense and social security in total dollar use. The Department of Health, Education and Welfare is the number one cost agency in the government. Based on these staggering statistics, there seems to be a tacit assumption that significant waste is occurring in use of medical dollars.

However again, the problem of definition arises, there being little agreement on the definitions of "waste" or "unnecessary" in these medical-political circles. In a study conducted by Herbert Dannenberg of the State of Pennsylvania, groups of patients using family practitioners or general surgeons as primary care physicians were compared. It was found that the latter group, with the same symptoms and illnesses, underwent twice as many surgical procedures as the former with no measurable increased health benefits over those in the F.P. group. Dannenberg labeled this "unnecessary" surgery.

Considering all this, the following points emerge as questions deserving all physicians' attention:

1. Is cost consciousness incompatible with humanistic medicine? (Can all physicians practice effective cost-conscious medicine?) For an interesting discussion see reference 10.
2. Is the excessive cost of dying, $14,000 in the average intensive care unit, really necessary for the majority of patients who die in hospitals?
3. In order to provide equal care for all individuals and not increase total cost, won't it be necessary to take care away from some individuals to provide it to others?
4. How can we restrain the enthusiastic adoption of widely promoted but unproven new medical technologies?
5. Is unrestrained expansion of expensive critical care facilities really justified in these days of restricted resources (consider for example, the number of new intensive care beds recently added at one of the Tampa hospitals)?
6. How much as the government contributed to increased health care cost by its subsidization and promotion of unhealthy practices such as low cost distribution of alcoholic beverages in the armed forces, licensure of medical cultism, subsidies for the tobacco industry, and most recently, an attempt to license the use of laetrile.

Finally as we ponder these problems, consider the ramifications of the fact that 60-70% of all Medicare dollars are spent on patients during their last year of life. Is this an indication of our meeting real needs, or of a failure of responsible physician decision-working?

Dr. John Knowles, President of the Rockefeller Foundation, believes the answer lies in more attention to prevention of disease, particularly, that due to personal behavior, eating patterns, and an unhealthy environment. Although one might look to the physician for leadership in this area, he laments, "Alas, the medical profession isn't interested because the intellectual, emotional and financial rewards of the present system are too great and because there is no incentive and very little demand to change."

Ultimately, however, it is clear that cost-containment in concert with good health care cannot be legislated, but must derive from judicious application of health dollar resources by medical practitioners; the quinessential ingredients in American health.

(References available upon request.)

Charles P. Craig, M.D.
Tampa

Reprinted from The Bulletin of the Hillsborough County Medical Association, June 1977.

Will Power

Through your will you have the power to help fight the heart diseases that will cause one out of every two deaths this year.

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Physician Discipline

The most persistent issue that lay on the door step of the HCMA over the summer has been the one relating to physician discipline.

This sensitive and difficult area in the administration of the affairs of organized medicine is seriously misunderstood by the lay public. The task of separating the authority of the state licensing board, the influence of the medical associations and the strength of hospital staffs in the public mind is a part of the public relations effort we need to conduct.

Medicine's model is different from any other profession. The peer review mechanism in hospitals is the front line of quality control. Other professions would do well to copy the medical model. It works reasonably well, but it receives little public attention. More visible to the public and press are the activities of medical associations and licensing boards.

It's necessary that the lay community understands the limitations of a medical association. We are a voluntary organization, privately funded and operated. We can discipline only our own members, not all licensed physicians. The extent of that discipline runs only to the status of membership in the association. Beyond the point of membership limitation or denial, we can only inform the licensing board of our actions.

Medical associations have no subpoena power. We can compel no testimony, and we must conduct investigations with volunteers and voluntary sources of information. It is beyond the scope of this association to directly attack a member's or non-member's right to a license under Chapter 458 of the Florida Statutes. Unlike the Bar Association, membership or non-membership carries no legal weight.

It has been suggested in the legislature that there be created an integrated Bar of Medicine which would be similar to the lawyers' bar. Under such a system membership in the Florida Medical Association would be mandatory in order to hold a license. The Board of Medical Examiners, appointed by the Governor, would be the Judicial Council and Membership Committee of the Medical Association. It would govern membership and discipline. The State Supreme Court serves in this capacity for the legal bar. County medical associations, their boards of censors and grievance committees would be deputies of the medical board with perhaps some state funding. Disciplinary actions at the county level would be subject to state appellate procedures much as we now have in the Florida Medical Association.

While these proposals are quite radical, they do suggest an approach to dealing with a dilemma. At the moment, we in organized medicine are being held publicly responsible for medical practice quality without the power or resources to carry out that publicly perceived responsibility. Perhaps medicine would find a way out of the disciplinary problems by studying such proposals or modifications of them.

However, whether or not we even consider such radical proposals, we would do well to seek ways to improve our present system. The need for this was expressed at the FMA Annual meeting in May when the Delegates approved Recommendation No. 4 of the Committee on County Medical Society Presidents:

"That grievance committees, Judicial Councils, etc. are becoming quasi-public bodies in peer review procedures and must follow legal processes. We need to have a definite manual of procedure if we are going to continue these efforts and we need to greatly expand the State Board of Medical Examiners' investigative staff to investigate and make recommendations. We favor a manual that precisely outlines procedures on a local level, as we feel that no one can know the situation as well as those on the local scene."

Richard S. Hodes, M.D.
Tampa

Reprinted from The President's Page of the Bulletin of the Hillsborough County Medical Association, Inc., October 1977.

Dr. Hodes is President of the Hillsborough County Medical Association and Treasurer of the Florida Medical Association.

Cracker Cures

Rheumatism

Three grapefruit, 3 oranges, 3 lemons, 3 tablespoons full of Epsom salts, 3 tablespoons cream of tartar. Wash and seed all fruit. Run fruit through food chopper and add salts and cream of tartar, then pour in one quart of boiling water and let stand 12 hours. Then strain and bottle and keep on ice. Dose: 1 tablespoon 3 times a day before meals.

Reprinted by permission from "Cracker Cures," a publication by the Peace River Valley Historical Society. Edited by Cedric Stephen Wood, P.E. These cures have been collected over the years by friends and members of the Peace River Valley Historical Society and presented a few at a time at each of their regular meetings by Dr. Gordon H. McSwain, custodian.

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MEETINGS

Approved by the FMA Committee on Continuing Medical Education

MARCH

Urinary Incontinence in Women, Mar. 1, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

5th Annual Selected Topics in Urology, Mar. 2-4, Gainesville Hilton, Gainesville.**

First International Congress on Colonoscopy and Disease of the Large Bowel, Mar. 2-4, Fontainebleau Hotel, Miami Beach. For information: John P. Christie, M.D., 7400 N. Kendall Drive, Suite 311, S. Miami 33156.

Hepatobiliary Disease in Clinical Practice, Mar. 2-4, Miami.*

Perinatology II High Risk Pregnancy Conditions and Their Management, Mar. 2-4, Hyatt House, Orlando. For information: Amelia C. Cruz, M.D., University of Florida College of Medicine, Department of Obstetrics and Gynecology, Box J-294, JHMHC, Gainesville 32610.

Problems in Rheumatology, Mar. 2-5, Don Cesar Beach Resort Hotel, St. Petersburg.+

Management of Diabetes Mellitus, Mar. 3, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

Modern Management of Common Skin Disease, Mar. 3-5, Carrillon Hotel, Miami Beach.*

Postgraduate Seminar in Dermatology, Mar. 3-5, Miami.*

3rd Annual Conference in Skin Disorders for Nurses, Mar. 3-5, Miami.*

Eighth Annual Radiological Special Procedures Seminar, Mar. 4-7, Konover Hotel, Miami Beach. For information: Mrs. Lucy Kelley, 6752 S.W. 34th Court, Miramar 33023.

Gateway Cancer Symposium, Mar. 6-8, Orlando Hyatt House, Kissimmee. For information: Charles Taylor, 1001 S. MacDill, Tampa 33609.

Mediclinics 1978, Mar. 6-17, Galt Ocean Mile Hotel, Fort Lauderdale. For information: Donald R. Lannin, M.D., 832 Central Medical Building, St. Paul, Minnesota 55104.

16th Annual Clinical Radiology Seminar "Controversies in Radiology," Mar. 7-11, Konover Hotel, Miami Beach. For information: Mrs. Lucy Kelley, 6752 S.W. 34th Court, Miramar 33023.

GYN Seminar, Mar. 9, Mercy Hospital Conference Center, Miami. For information: James Jude, M.D., 3663 South Miami Ave., Miami 33133.

Symposium on Ocular Trauma, Mar. 11, Tampa.+

***For information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

Annual Obstetrical and Gynecological Cruise Seminar, "Outpatient Diagnosis and Management," Mar. 11-21 on the Federico C. For information: William A. Little, M.D., Dept. of OB-GYN, U. of Miami School of Medicine, Box 520875, Biscayne Annex, Miami 33152.

2nd Annual Seminar "Special Aspects of Computed Tomography," Mar. 12-15, Konover Hotel, Miami Beach.*

Invasive Cardiological Techniques, Mar. 13, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Mar. 13-18, Miami.*

Respiratory Management: 1978, Mar. 13, 20 & 27, simultaneously at Broward General Medical Center, Mt. Sinai Medical Center and South Miami Hospital, Miami. For information: Adam Wanner, M.D., 830 Brickell Plaza, Miami 33131.

Practical Aspects of Ultrasonography, Mar. 15-18, Konover Hotel, Miami Beach.*

A Look Forward: Recent Advances in Emergency Medicine, Mar. 16-19, Omni International Hotel, Miami. For information: Registrar, Sixth PGS, 600 Courtland St., Suite 420, Orlando 32804.

Frontiers in Heart Disease - 1978: Current Practices and Future Trends, Mar. 17-18, Cedars of Lebanon Hospital, Miami. For information: Thelma MacGregor, P.O. Box 520793, Miami 33152.

Infectious Disease and Immunology, Mar. 17-18, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D. or Samuel E. Crockett, M.D., 1416 South Orange Avenue, Orlando 32806.

Clinical Family Planning for Physicians, Mar. 20-21, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Current Clinical Concepts in Otolaryngology, 1978, Mar. 22-24, Miami.*

Tenth Teaching Conference in Clinical Cardiology, Mar. 22-25, Americana Hotel, Miami Beach. For information: Michael S. Gordon, M.D., Ph.D., University of Miami School of Medicine, Division of Cardiology, P.O. Box 520875, Biscayne Annex, Miami 33152.

9th Annual Topics in Internal Medicine, Mar. 23-25, Gainesville Hilton, Gainesville.**

Seminar for Chronic Pain, Mar. 31-Apr. 2, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

APRIL

New Concepts Toward Better Health Care, Apr. 1-2, Eden Roc Hotel, Miami Beach.*

1978 CME Sequential Review Courses, Apr. 1—June 24 at 9:00 a.m. - 12:30 p.m. on Saturdays in Daytona and Tampa, and Sundays in St. Petersburg and Orlando from Apr. 1-June 24 (excluding Memorial Day weekend May 27).

Treatment of Violence, and Violence in Our Society, Apr. 6, Kapok Tree Inn, Fort Lauderdale. For information: Ms. Peggy Jackson, 330 S.W. 27th Ave., Fort Lauderdale 33312.

Malignant Hyperthemia, Apr. 6-9, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 10-15, Miami.*

Fifth Annual Scientific Session, Apr. 11-14, Hilton Hotel, Jacksonville. For information: Charles L. Gaudry Jr., M.D., Department of Family Practice, Naval Regional Medical Center, Jacksonville 32201.

Basic ECG for the Primary Physician, Apr. 13-16, Hyatt Regency Hotel, New Orleans. For information: Caral Sparks, EMSS, 3900 N.W. 79th Ave., Miami 33166.

Obstetric Anesthesia — Fourth Annual Seminar in Memory of Virginia Apgar, M.D., Apr. 14-16, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Sixth Annual Intensive Care Symposium, Apr. 15-17, Miami.*

Emergencies in Internal Medicine, Apr. 17-20, Miami.*

Advanced Electrocardiography and Arrhythmia Management for the Family Practitioner, Apr. 20-22, Gainesville Hilton, Gainesville.

Law and Emergency Medicine, Apr. 20-22, Key Biscayne Hotel, Key Biscayne, Miami. For information: Caral Sparks, EMSS, 3900 N.W. 79th Ave., Suite 469, Miami 33166.

ENG (Electronystagmography) Seminar and Workshop, Apr. 28-29, Orlando.*

MAY

Second Annual Symposium on Underwater Medicine, May 4-8, Miami.*

Seizure Disorders, May 5, VA Center, Bay Pines. For information: John C. Gallagher, M.D., Chairman, Education Committee, VA Center, Bay Pines 33504.

Newer Clinical Perspectives in the Management of Myocardial Infarction and Coronary Artery Disease, May 5-6, Barefoot Beach Inn/Sheraton Motor Inn, Panama City Beach. For information: Ernest G. Haslam, M.D., P.O. Box 491, Panama City 32401.

Oncology in Community Practice, May 8, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Boulevard., Inverness 32650.

Post-Convention Seminar and Diving Program, May 8-11, Miami.*

Orthopedic Seminar, May 11, Mercy Hospital Conference Center, Miami. For information: James Jude, M.D., 3663 South Miami Ave., Miami 33133.

Pars Plana Vitreous Surgery — The Miami Technique, May 11-13, Miami.*

Clinical Family Planning for Physicians, May 15-16, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th St., Jacksonville 32209.

Family Medicine Update — 1978, May 18-21, Miami.*

7th Family Practice Review, May 22-26, Gainesville Hilton, Gainesville.**

JUNE

Review Course for Certification In Internal Medicine, June, Miami.*

The Private Practice of Psychiatry, June 8, Mercy Hospital, Miami. For information: Bernard Tumarkin, M.D., 3663 South Miami Ave., Miami 33133.

Bascom Palmer Eye Institute Alumni Meeting and Seminar, June 9-11, Miami.*

Florida Suncoast Pediatric Conference, June 12-14, Sheraton Sand Key, Clearwater.+

Coronary Disease, Exercise Testing and Cardiac Rehabilitation, June 23-25, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

Fifth Annual Postgraduate Seminar in Respiratory Care, June 23-25, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Seminar for Intensive and Critical Care Personnel, June 23-25, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

JULY

Examination of the Arterial System, July 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 522 West Highland Boulevard, Inverness 32650.

SEPTEMBER

Transient Ischemic Attacks: The Computerized EEG, Sept. 11, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.

Anesthesiology Review and Update, Sept. 15-17, Sonesta Beach Hotel, Key Biscayne. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

NOVEMBER

Adolescent Medicine, Nov. 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

DECEMBER

7th Annual Refresher Lecture Course for Nurse Anesthetists, Dec. 1-3, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Remember always that you have not only the right to be an individual; you have an obligation to be one. You cannot make any useful contribution in life unless you do this.

Eleanor Roosevelt

CLASSIFIED ADS

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GENERAL PRACTITIONER: For well equipped medical clinic immediately adjacent to 120 bed skilled nursing facility; would also act as medical director for nursing home. Salary 100% of intake. Contact: Administrator, Wakulla Manor Nursing Home, P.O. Box 508, Crawfordville, Florida 32327. Phone: (904) 926-7181.

FAMILY PRACTITIONER OR INTERNIST WANTED to share facilities with four practitioners in solo practice. Major equipment provided. Rent $250 per month. Competent laboratory and x-ray with income based on use. Bookkeeping system and receptionist shared. Financial assistance available to right party. Contact: T. C. Kenaston Jr., M.D., Box 550, Cocoa, Florida 32922.

FAMILY PRACTITIONER, board certified and Florida licensed, needed by multispecialty 20 man group in North Miami Beach. Send curriculum vitae to The Aventura Medical Center, 2956 Aventura Boulevard, North Miami Beach, Florida 33180. Phone: (305) 891-4211.

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Situations Wanted

ORTHOPEDIC SURGEON, 30, married, university trained, available July 1978. Experienced in total joint replacement, desires partnership, group or solo on Florida coast. American, Bilingual. Spanish-English. Write C-794, P.O. Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST-CERTIFIED CP/AP, 47, Florida licensed, native U.S., excellent C.V. and experience as director. Current post-grad, training and certification through 1980. Write: P.O. Box 11158, U.S. Post Office, 333 E. Ontario St., Chicago, Illinois 60611.

30 YEAR OLD FMG WITH FLEX-ECFMG and Florida license, board eligible, general surgery. Presently doing one year of

peripheral vascular surgery. Desires solo, partnership or group. Will consider all locations in Florida. Contact: Antonio Vasquez, M.D., 2799 W. Grand Blvd., Detroit, Michigan 48202.

INTERNIST-ENDOCRINOLOGIST, 30, ABIM certified, university trained. Seeks partnership or group practice in Southeast Florida beginning 7/78. Write C-830, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN: 37 years old; Florida license, board eligible; neonatology subspecialty. Seeks partnership, group or hospital based practice. Desires relocation. Available January 1978. Contact: E. P. Nelson, M.D., 903 Hensley Heights, Man, West Virginia 25635.

THORACIC CARDIOVASCULAR GENERAL SURGEON, now Clinical Professor of Surgery, wishes to transfer practice to Florida. Association or group desired. Hospital full time also considered. Write C-835, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL AND VASCULAR SURGEON, 35, university trained, board certified, Florida licensed. Seeks practice opportunity, solo, partnership or group. Available 3 months notice. Write C-837, Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN, 33 years, university trained, board eligible, available in February 1978, seeks practice opportunity in Florida. Call (304) 583-9592 after 5 p.m.

PEDIATRICIAN — board eligible, clinical and administrative experience in community/ambulatory pediatrics. Desires to join group, preferably university associated. Write C-851, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSICAL THERAPIST, 36, highly motivated. Florida licensed, interested in partnership with hospital or orthopedic physicians. Ten (10) years excellent experience, heavily geared toward orthopedics. Knowledge of fracture bracing and skeletal traction. Proven clinical and business record. Experience in starting new departments. Interested in a permanent situation. References and resume upon request. Write C-849, P.O. Box 2411, Jacksonville, Florida 32203.

OPHTHALMOLOGIST, 34, completing university glaucoma fellowship June 1978, seeking association or purchase of practice, prefer greater Miami area. Call (212) 427-2915. Alan Kohn, M.D., 305 E. 86th St., New York, N. Y. 10028.

BOARD CERTIFIED INTERNIST, GASTROENTEROLOGY specialty seeking position with income guarantee for July 1978. Rajkumar Warrier, M.D., 68-A Manhattan Court, Brooklyn, New York 11235. Phone: (212) 332-3951.

INTERNIST, 29, ABIM eligible after completing residency. Has ER experience, seeks partnership or group in S. E. Florida. Available July 1978. Write C-852, P.O. Box 2411, Jacksonville, Florida 32203.

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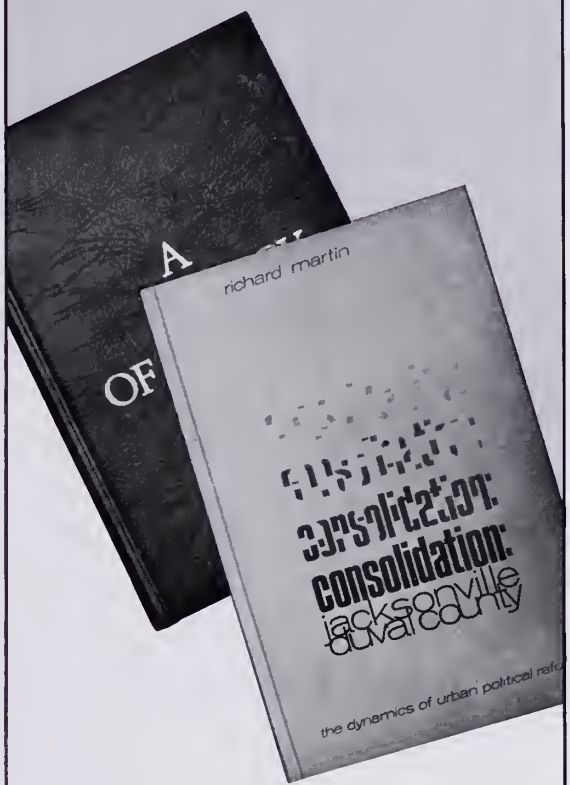
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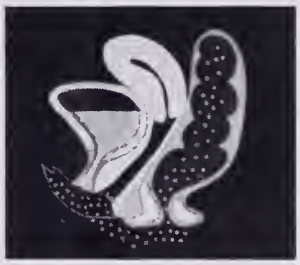
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40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
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Adverse Reactions to Plants in Florida

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This Issue

We are indebted to Dr. L. E. McHenry and Dr. Philip Blank for collaborating to bring this special issue on "Adverse Reactions to Plants in Florida" to our readers and we are most grateful to the authors who contributed to this issue of The Journal.

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Special Issue

Adverse Reactions to Plants in Florida

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OJ 357-7

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IMPORTANT NOTE—This information is a BRIEF SUMMARY of the complete prescribing information provided with the product and therefore should not be used as the sole basis for prescribing the product. This summary was prepared by deleting from the complete prescribing information certain text, tables, and references where indicated by the symbol [ ]. The physician should be thoroughly familiar with the complete prescribing information and patient information before prescribing the product. [ ].

INDICATION: Contraception [ ]

CONTRAINDICATIONS: Oral contraceptives (OC's) should not be used in women with any of the following conditions:

1. Thrombophlebitis, thromboembolic disorders or conditions which predispose to these disorders. 2. A past history of deep vein thrombophlebitis or thromboembolic disorders. 3. Cerebral vascular or coronary artery disease. 4. Known or suspected carcinoma of the breast. 5. Known or suspected estrogen-dependent neoplasia. 6. Undiagnosed, abnormal genital bleeding. 7. Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS:

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic. These studies estimate that users of oral contraceptives are 4 to 11 times more likely to develop these diseases without evident cause than are nonusers. Overall excess mortality due to pulmonary embolism or stroke is on the order of 1.0 to 3.5 deaths annually per 100,000 users and increases with age. In a collaborative American study of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than in nonusers and the risk of thrombotic stroke was 4 to 9.5 times greater in users than in nonusers. [ ]

An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported, confirming a previously suspected association. These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor. The annual excess case rate (increased risk) of myocardial infarction (fatal and nontatal) in oral contraceptive users was estimated to be approximately 7 cases per 100,000 women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group. [ ]

In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives. Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 50-80 mcg of estrogen. Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved. This finding has been confirmed in the United States. Cases of thromboembolic disease have been reported in women using progestin-only oral contraceptives, and they should not be presumed to be free of excess risk.

The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age. Oral contraceptives are, however, an independent risk factor for these events. [ ]

The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception. The estimates of risk of death for each method include the combined risk of the contraceptive method (e.g., thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure. This latter risk varies with the effectiveness of the contraceptive method. [ ] The study concluded that the mortality associated with all methods of birth control is low compared to the risk of childbirth, with the exception of oral contraceptives in women over 40, and that the lowest mortality is associated with the condom or diaphragm backed up by early abortion.

The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia. The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors. The use of oral contraceptives in women in this age group is not recommended.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e.g., thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately.

A four- to six-fold increased risk of post-surgery thromboembolic complications has been reported in oral contraceptive users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery. [ ]

2. OCULAR LESIONS. There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives. Discontinue oral contraceptive medication if there is unexplained, sudden or gradual, partial or complete loss of vision; sudden onset of proptosis or diplopia; papilledema; or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures.

3. CARCINOMA. Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver. [ ]

In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives. [ ]

One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in subgroups of oral contraceptive users with documented benign breast disease. A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented.

In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of all women taking oral contraceptives is, nevertheless, essential. In all cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception.

4. HEPATIC ADENOMA. Benign hepatic adenomas appear to be associated with the use of oral contraceptives. Although benign, and rare, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage. This has been reported in short-term as well as long-term users of oral contraceptives, although one study relates risk with duration of use of the contraceptive. While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock.

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. [ ]

5. USE IN PREGNANCY, BIRTH DEFECTS IN OFFSPRING, AND MALIGNANCY IN FEMALE OFFSPRING. The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception. Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes.

Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case control study has estimated a 4.7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal withdrawal tests for pregnancy or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 live births.

In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestins are effective for these uses.

There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives. Embryos with these anomalies are virtually always aborted spontaneously. Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown.

Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks.

It is also recommended that women who discontinue oral contraceptives with the intent of becoming pregnant use an alternate form of contraception for a period of time before attempting to conceive. Many clinicians recommend 3 months.

The administration of progestin-only or progestin-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6. GALLBLADDER DISEASE. Studies report a doubling of the risk of surgically confirmed gallbladder disease in users of oral contraceptives or estrogen for 2 or more years.

7. CARBOHYDRATE AND LIPID METABOLIC EFFECTS. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives.

An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives.

8. ELEVATED BLOOD PRESSURE. An increase in blood pressure has been reported in patients receiving oral contraceptives. In some women hypertension may occur within a few months of beginning oral contraceptive use. In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers. The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year. Age is also strongly correlated with the development of hypertension in oral contraceptive users. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives.

9. HEADACHE. The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause.

10. BLEEDING IRREGULARITIES. Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind. In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy. [ ] Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since this may increase the risk of thromboembolic disease.

Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives. Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods.

11. ECTOPIC PREGNANCY. Ectopic as well as intrauterine pregnancy may occur in contraceptive failures. However, in oral contraceptive failures, the ratio of ectopic to intrauterine pregnancies is higher than in women who are not receiving oral contraceptives, since the drugs are more effective in preventing intrauterine than ectopic pregnancies. [ ]

12. BREAST FEEDING. Oral contraceptives given in the postpartum period interfere with lactation. There may be a decrease in the quantity and quality of the breast milk. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. [ ] If feasible, the use of oral contraceptives should be deferred until the infant has been weaned.

PRECAUTIONS: General 1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than 1 year without another physical examination being performed. 2. Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size. 3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree. Patients becoming significantly depressed while taking oral contraceptives should stop the medication. 4. Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, or cardiac or renal insufficiency. 5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy. If jaundice develops in any patient receiving such drugs, the medication should be discontinued. 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients. 7. Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency. 8. Serum folate levels may be depressed by oral contraceptive therapy. Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency. 9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted. 10. Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Decreased pregnanediol excretion.

e. Reduced response to metyrapone test.

INFORMATION FOR THE PATIENT (See Patient Package Insert)

DRUG INTERACTIONS: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin. [ ]

ADVERSE REACTIONS: An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see WARNINGS):

Thrombophlebitis; pulmonary embolism; coronary thrombosis; cerebral thrombosis; cerebral hemorrhage; hypertension, gallbladder disease, congenital anomalies.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed:

Mesenteric thrombosis; benign hepatomas; neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related:

Nausea, usually the most common adverse experience; vomiting reaction, occurring in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally; gastrointestinal symptoms (such as abdominal cramps and bloating); breakthrough bleeding; spotting; change in menstrual flow; dysmenorrhea, amenorrhea during and after treatment; temporary infertility after discontinuance of treatment; edema; chloasma or melasma which may persist; breast changes: tenderness, enlargement and secretion; change in weight (increase or decrease); change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum; cholestatic jaundice; migraine; increase in size of uterine leiomyomata; rash (allergic); mental depression; reduced tolerance to carbohydrates; vaginal candidiasis.

The following adverse reactions have been reported in users of oral contraceptives, and the association has been neither confirmed nor refuted:

Premenstrual-like syndrome; intolerance to contact lenses; change in corneal curvature (steepening); cataracts; changes in libido; chorea; changes in appetite, cystitis-like syndrome, headache; nervousness; dizziness, hirsutism; loss of scalp hair; erythema multiforme, erythema nodosum; hemorrhagic eruption, vaginitis, porphyria, impaired renal function.

ACUTE OVERDOSE: Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females. [ ]

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Depression Today

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The University of Chicago/The Pritzker School of Medicine

PARTICIPANTS:

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University of Oregon Health Science Center & private practice, Portland, Oregon
CARROLL L. WITTEN, M.D.
University of Louisville School of Medicine & private practice, Louisville, Kentucky

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TIME ZONES

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3:00 p.m. Central
4:00 p.m. Eastern

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100	Pavabid (150 mg.)	11.73	Papaverine HCl T.R. (100 mg.)	**4.33**	**7.40**
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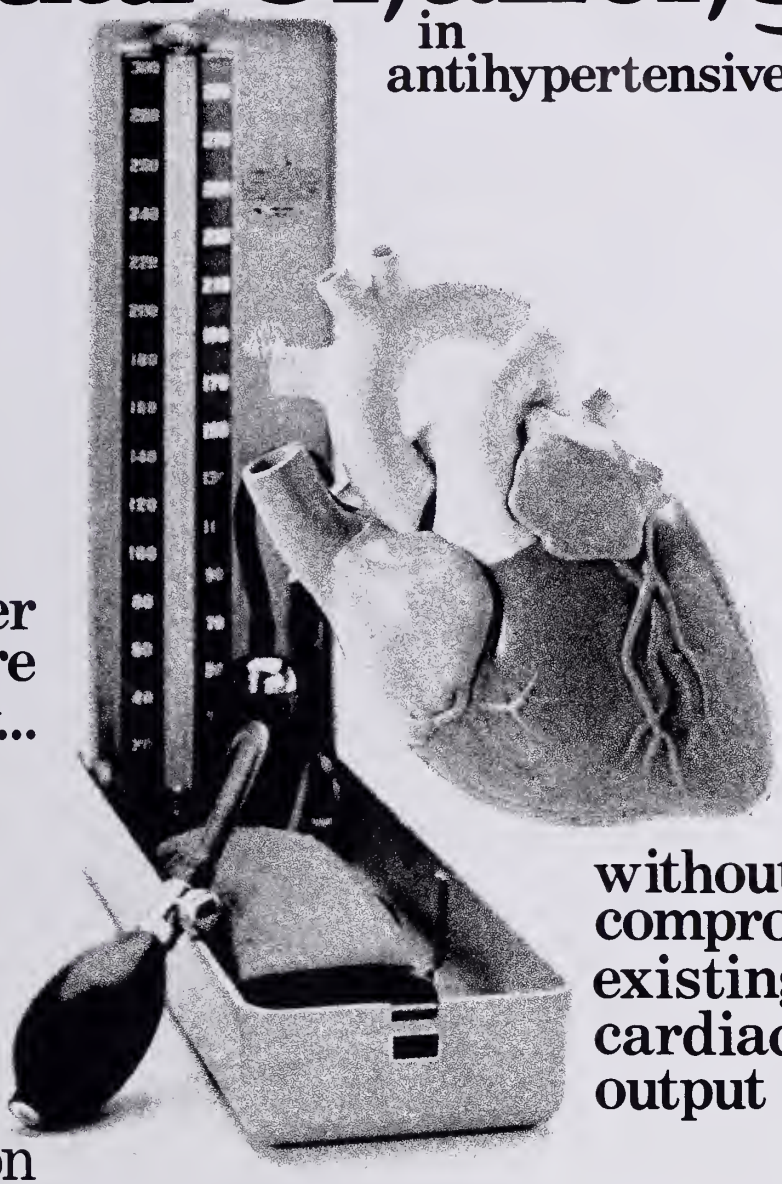
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to lower blood pressure effectively...

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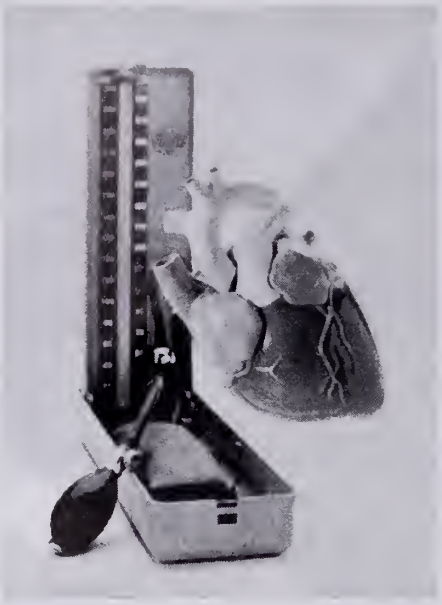
ALDOMET® (METHYLDOPA | MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function–cardiac output is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.
It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

MSD
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in hypertension

ALDOMET®

(METHYLDOPA|MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function– cardiac output is usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

For more detailed information, consult your MSD representative or see full prescribing information.

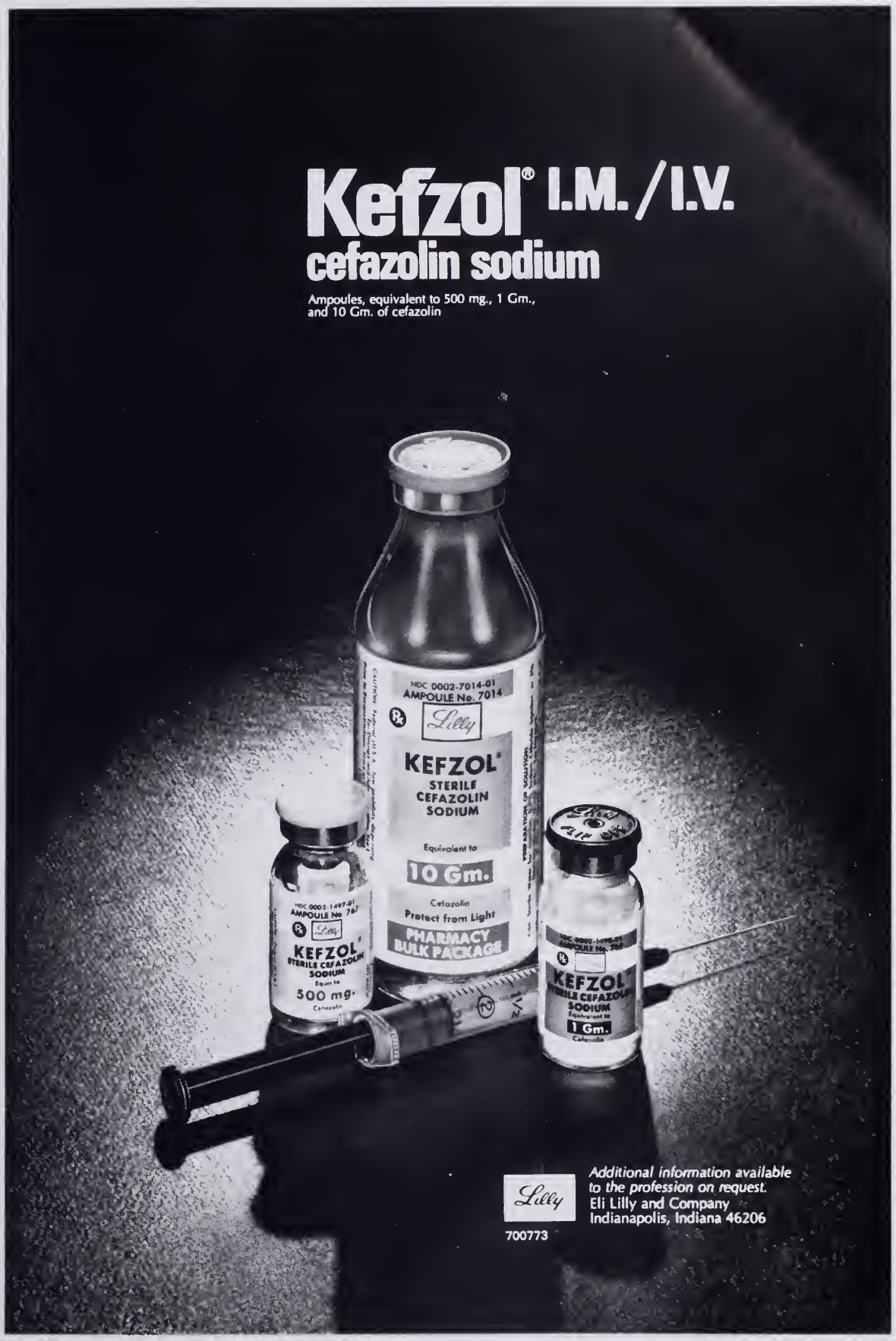
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Dean's Page

A Mixed Perception?

William B. Deal, M.D.

A recent Special Report from the Robert Wood Johnson Foundation concerning the access to medical care reveals some interesting facts. The report is based on a survey conducted between September, 1975 and February, 1976 by the Center for Health Administration Studies of the University of Chicago. Statistically, the population sample of 7,787 persons is representative of the United States population and certain parts of the survey were comparable to similar projects completed in 1963 and 1970.

Since 1963 the percentage of people seeing physicians has increased to 78%. The percentage of blacks consulting physicians increased from 50% in 1963 to 75% in 1976. The largest gain occurred in the inner city.

When viewed according to income level, the middle and lower income groups receiving care increased to almost the same percent as the high income group (80%). This reflects a dramatic change since 1963. With the implementation of Medicaid and Medicare in 1966, some increase should have been expected.

In contrast, the study shows that there continues to be an excellent correlation between the availability of dental services and income level, that is, the lower the income, the less utilization of dental services occurs. This parallels the availability of dental insurance.

Of the people consulting physicians during the survey, 88% were satisfied with their visit. This overwhelming positive response to individual care does not reflect the opinion of the **same** population when asked to respond to the following statement, "There is a crisis in health care today in the United States." Sixty-one percent agree, 26% uncertain, and 13% disagree!

This mixed perception may be secondary to the polling technique, that is, requesting a response to a statement versus answering a question, for example, "Is there a crisis in health care?" Further study is indicated. Nevertheless, it strongly suggests that we as physicians are rendering individual care admirably. However, the public perception of the existence of a crisis suggests: (A) the medical profession is not relating our story in a convincing manner, or (B) the public is being told there is a crisis and they believe it, totally discounting their own good experience.

Is health care in the United States in a "crisis"? Review the following facts: 1) the population increased by 26 million between 1960 and 1976 which is equal to the entire population of the United States in 1855. 2) the doctor population ratio has decreased from 1:719 to 1:617 between 1960 and 1976 reflecting the expansion of medical education. 3) most persons can reach their doctor within 30 minutes. 4) blacks and low income groups now have an almost equal access to health care. 5) two-thirds of the population can obtain an appointment within 48 hours. 6) the infant mortality rate has decreased 19% in the last five years.

One could go on and on. Progress is being made and the "crisis" is simply one problem that we **all** recognize: increasing costs. The DHEW 1979 budget request for health does not curtail costs however, a 12% increase! Consider the increase requested for PSRO and Medicare Certification of Providers: 22%. Do the federal policymakers understand the public mind? Allen Parachini of the **Chicago Sun Times** wire service recently wrote: "In all, there is in this country a serious failure of communication between the health leaders and the led. That, of course, is not unique in the public health sector. But it is more avoidable here than in fields like arms control because health and the way the public perceives it is never distant from public consciousness."

We must close the communication gap.

Dr. Deal is Acting Dean of the University of Florida College of Medicine, Gainesville.

● Dr. Deal, University of Florida College of Medicine, Gainesville 32610.

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* **INDICATIONS:** Based on a review of this preparation by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: **Possibly effective:** In cutaneous candidiasis; superficial bacterial infections; the following conditions when complicated by candidal and/or bacterial infection: atopic, eczematoid, stasis, nummular, contact, or seborrheic dermatitis, neurodermatitis, and dermatitis venenata; infantile eczema; lichen simplex chronicus; and pruritus ani and pruritus vulvae.

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis; history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely establish therefore, do not use extensively on pregnant patients, in lc amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsuscept organisms (including fungi other than candida). Should superin tion due to nonsusceptible organisms occur, administer suitc concomitant antimicrobial therapy; if favorable response is not pror discontinue the preparation until adequate control by other c infectives is effected. If extensive areas are treated or if the occlu technique is used, the possibility exists of increased systemic abs tion of the corticosteroid; suitable precautions should be taker irritation develops, discontinue the product and institute appropr therapy.

ADVERSE REACTIONS: Sensitivity reactions to topical use of gramic are rare. Hypersensitivity to nystatin is extremely uncommon. Hy sensitivity to neomycin has been reported and articles in the cur medical literature indicate an increase in its prevalence.

The following local adverse reactions have been reported topical corticosteroids either with or without occlusive dressings: b ing sensations, itching, irritation, dryness, folliculitis, secondary in tion, skin atrophy, striae, miliaria, hypertrichosis, acneform erupti maceration of the skin, and hypopigmentation. Contact sensitivity particular dressing material or adhesive may occur occasionally. toxicity and nephrotoxicity have been reported.

For full prescribing information, consult package insert.

HOW SUPPLIED: Available in 15, 30, and 60 g. tubes. It is also o able in jars of 120 g. (4 oz.) for hospital or institutional use only.

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C III

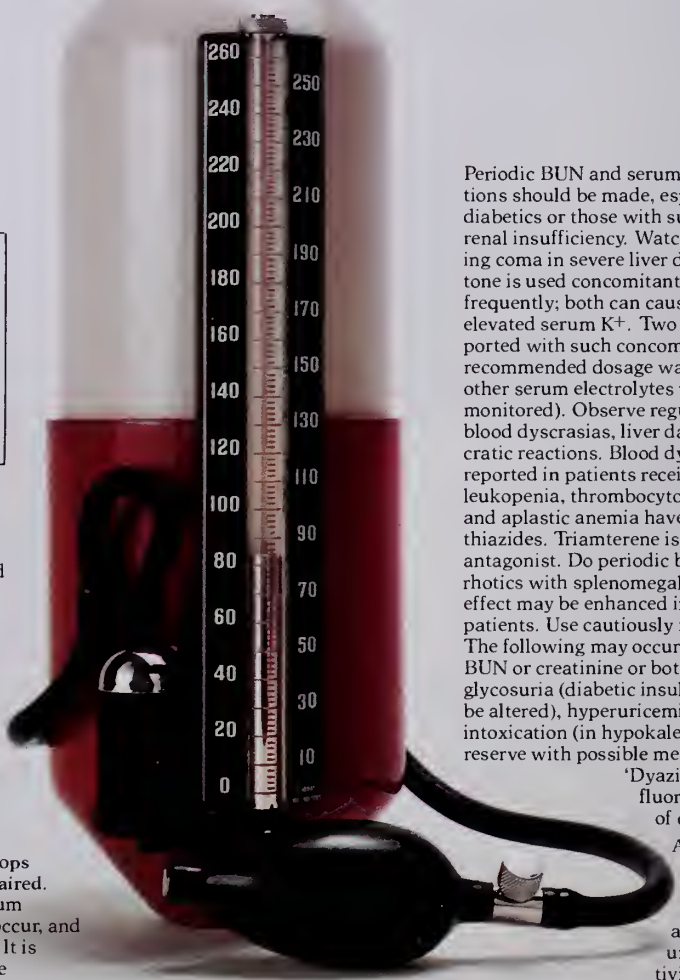
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MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

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FROM THE EDITOR'S DESK

All 50 states enacted some sort of medical malpractice legislation during 1975 and 1976. According to a report commissioned by the Department of HEW, the legislation covered eight major changes in tort law and procedure. Included were clarification of informed consent (22 states), limitation on damages (8 states), modification of statutes of limitation (34 states), limitation on contingency fees (20 states), and payment of damages in periodic installments (13 states).

Blue Shield of California has replaced Blue Shield of Florida as the contractor for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in Florida. The switch became effective on February 1. Florida CHAMPUS claims should be sent to Blue Shield of California, P. O. Box 85022, San Diego, Calif. 92138.

Medical leadership has scored significant gains in public confidence. A Harris survey released in January indicated that 55% of the public have "a great deal of confidence" in medical leadership, compared with 46% a year earlier. This was the highest vote of confidence among 16 "institutions" tested. Scoring second to medical leadership was higher education (41%). Only the press failed to post a gain in public confidence from 1976 to 1977.

NBC-TV's three-hour documentary on medicine in America has been hailed by the AMA as "a major contribution to public understanding of the complexities of our health care system." The program, *Medicine in America: Life, Death and Dollars*, was shown on January 3. In a letter to NBC, AMA Executive Vice President James H. Sammons, M.D., wrote, "the program described health care in the United States in a fair and balanced manner, and I was pleased that many of the points covered were consistent with longstanding Association goals and policies."

A survey by the University of Chicago Center for Health Administration reveals that 88% of the American people are "satisfied" with their health care. The same survey indicates that no one population group has great trouble getting to see a doctor. Nevertheless, 61% of those polled believe there is a health care "crisis." In another survey, a Health Systems Agency poll of a populous Chicago suburban area showed that 93% were either "satisfied" or "very satisfied" with their care.

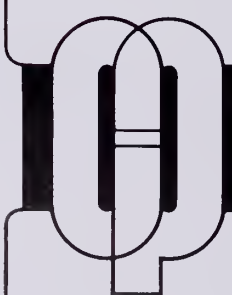
The number of Americans living in physician shortage areas could increase by 56% to a total of 25 million under new criteria proposed by HEW's Bureau of Health Manpower. Under current rules a shortage level is reached when there are 4,000 or more persons for each primary care physician. The proposed new rule would lower this to 3,500. Should the lower figure be adopted, more communities would qualify for federal help through the National Health Service Corps and other programs.

The Pennsylvania Medical Society has gone to court to get $2.4 million in licensing and relicensing fees returned to the board of medical examiners. The funds earn interest that is absorbed into the state's general revenue fund. The suit stems from frustrated efforts of the state medical society to establish a more active medical board.

The Editor

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- ☐ We want to make our employees more aware. We will carry an article about child abuse in our company publication.
- ☐ We will volunteer our employees' time and talent to community child abuse prevention programs.
- ☐ We will plan a day for employees' children to visit our place of work to learn what we do and why.
- ☐ I don't spend enough time with my children. Tonight I am going home early to find out who my children are.
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National Committee for Prevention of Child Abuse

Our new Medical Necessity Program has two worthy goals:

(1) To help contain costs.
(2) To upgrade medical care.

This program initially identifies 28 surgical and diagnostic procedures which will not be paid routinely by Blue Shield. All pertinent claims will be reviewed for medical necessity and covered only when a clear need can be proven.

Following is a list identifying the 28 surgical and diagnostic procedures:

1. Ligation of Internal Mammary Arteries, Unilateral or Bilateral
2. Radical Hemorrhoidectomy, Whitehead Type
3. Omentopexy — Portal Obstruction
4. Kidney Decapsulation, Unilateral and Bilateral
5. Perirenal Insufflation
6. Nephropexy
7. Circumcision, Female
8. Hysterotomy
9. Supracervical Hysterectomy
10. Uterine Suspension
11. Uterine Suspension with Presacral Sympathectomy
12. Hypogastric or Presacral Neurectomy
13. Fascia Lata by Stripper — when used to treat lower back pain
14. Fascia Lata by Incision — when used to treat lower back pain
15. Ligation of Femoral Vein, Unilateral and Bilateral — when used to treat Post Phlebitic Syndrome
16. Excision of Carotid Body Tumor — when used to treat Asthma
17. Sympathectomy, Thoracolumbar, Unilateral or Bilateral — when used to treat Hypertension
18. Sympathectomy, Lumbar — when used to treat Hypertension
19. Basal Metabolic Rate — BMR
20. Protein Bound Iodine — PBI
21. Icterus Index
22. Ballistocardiogram — BCG
23. Phonocardiogram with Interpretation and Report
24. Angiocardiography, using Carbon Dioxide, Supervision and Interpretation Only
25. Angiocardiography, Single Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
26. Angiocardiography, Multi-Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
27. Angiography — Coronary, Unilateral, Selective Injection, Supervision and Interpretation Only, Single View unless in an Emergency
28. Angiography Extremity

This program was developed in cooperation with The American College of Physicians, The American College of Surgeons and The American College of Radiology. We ask your support in making our Medical Necessity Program 100% effective.*

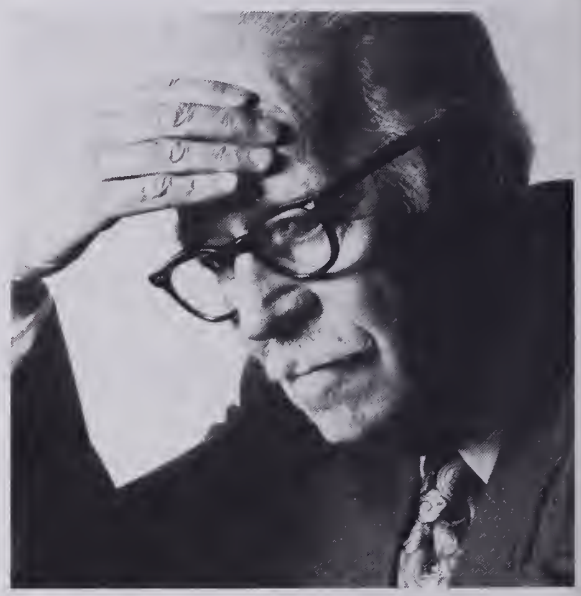
*A claims review by The Florida Plan indicated that most of the procedures were already being screened for medical need and few of the services in question were being performed in Florida.



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THERAPEUTIC FOOTNOTE: IN TREATING ANGINA . . . FAILURES MAY RESULT FROM INADEQUATE DOSAGE
Reports in the literature indicate the usefulness of higher dosage levels of isosorbide dinitrate.[1,2]

INDICATIONS: Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

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1. Shane, S.J.: Canadian Family Physician, November 1973. 2. Lemberg, L.: Practical Cardiology, February 1976.

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Special Issue

Adverse Reactions to Plants in Florida

INTRODUCTION

Julia F. Morton, D.Sc.

Oh! could we wake from sorrow; were it all
A troubled dream like this, to cast aside
Like an untimely garment with the morn;
Could the long fever of the heart be cool'd
By a sweet breath from nature; or the gloom
Of a bereaved affection pass away
With looking on the lively tints of flowers—
How lightly were the spirit reconciled
To make this beautiful bright world its home.
Willis
[From E. J. Lowe, "Beautiful Leaved Plants," London, 1872]

Plants are indispensable in our world—stabilizing, moisturizing and enriching the soil, cooling and cleansing the atmosphere, providing food, fodder, medicinal, structural and a host of other useful products, habitats for wildlife, and, not the least, interest and beauty. These esthetic values are those of which most people are most aware. Today, there is a great surge of feeling for plants transcending any other era in modern times. This is reflected in widespread efforts to protect natural areas and vanishing species, and in a general craving to surround one's self with greenery. Gardening is in vogue among city dwellers and suburbanites and there is even a trend back to rural abodes.

This plant-consciousness is, to be sure, largely beneficial, but it should be accompanied by at least some rudimentary awareness of plant chemistry. While the wishful thinker prefers to assume that all plants are "good," every reasonable person should be prepared to face the reality that many contain potent substances which can affect man and animals adversely. Such substances presumably contribute to the plants' survival—providing resistance to diseases and insects, attack by birds or other predators.

Some blooms release airborne pollen to fertilize neighboring plants of the same species; other blooms which need insects to transport their pollen excrete into the atmosphere chemical attractants which are recognized by humans as agreeable or disagreeable odors. An entire plant may be aromatic and give off chemicals (osmyls) which act as insect-repellents and these substances are usually found to be respiratory irritants. Some plants possess stinging hairs which inject irritant material on contact. Others may be more or less coated with hairs which mechanically irritate sensitive skin and some are armed with spines or thorns which are obvious hazards.

Certain groups of plants are characterized by gummy white sap (latex) that may be toxic externally and internally; or, while not toxic, capable of inflicting injury through the activity of a digestive enzyme; or entirely innocuous.

Plants, therefore, that cause adverse reactions in man and animals may be referred to as poisonous, or injurious, or as skin and respiratory irritants. In the light of modern science, we must now recognize another category—plants which are carcinogenic (tumor initiators) or co-carcinogenic (tumor promoters), and it is sobering to note that every plant which has displayed significant antitumor activity in scientific screening programs has been shown to be also carcinogenic. It is now necessary to warn that certain plant-derived foods or beverages formerly believed harmless may be dangerous if taken in excess, frequently, over a long period of time—particularly products of plants high in phenols, which include ordinary tea and dry red wine.

A number of dangerously poisonous plants furnish alkaloids or other active constituents which, properly administered in safe doses, are a boon to mankind. Not a few poisonous plants or plant parts, carefully detoxified, are important foods, locally or worldwide.

Some plants have toxic properties throughout; others only in certain portions—as seeds, bark, or roots. Several fruits of wide popularity, including apples, peaches, cherries, tropical sugar apples, soursops (guanabanas), and white sapotes, have wholesome, edible flesh or pulp but poisonous seed kernels. Many of us have eaten a few apple seeds or peach kernels with no ill effect but, in quantity, these can be seriously poisonous.

There are many factors which make the subject of plant hazards a complex and confusing one. The level of toxic constituents in plants may vary with the stage of growth and soil and climatic conditions. Some plant parts are edible when immature, toxic when mature; others are of the opposite nature.

In regard to internal poisoning, the toxic dose must be viewed in relation to bodily weight, a child being affected by a smaller amount than an adult, and some poisons are cumulative so that repetition may greatly increase the hazard. Especially risky are those toxins which produce a delayed reaction, for repeated ingestion may occur before symptoms appear.

External poisoning may also depend on repetition, the first contact merely sensitizing and subsequent contacts producing obvious reactions. Another problem is that people are prone to associate dermatitis with the last plant handled, whereas the actual source may be a plant contacted several hours or a day or two earlier but producing a delayed reaction (as do plants of the family Anacardiaceae). When injured parties lay blame on an unlikely suspect, I have learned to ask, "What else did you touch?" "What else did you do?", and the real cause of damage usually comes to light.

With respiratory irritants, too, ill effects may not be apparent at first but may develop after overexposure.

It is customary to refer to poisonous plants as especial hazards to children and it is true that children are the innocent victims of most plant/people accidents. Today, however, with the widespread back-to-nature attitude, adults are tending to unwisely ingest plant materials they would not have dreamed of eating ten years ago—before "grazing" became a fad. Through misguided enthusiasm, misidentification, or wrong motives (seeking hallucinogenic experiences), many adults are suffering plant-caused adverse reactions, some requiring hospitalization.

Since the establishment of Poison Control Centers in Florida hospitals (the first in 1954), there has been a growing awareness on the part of physicians and other health-care workers of the possibility of plant causation of untoward symptoms and many are keenly interested in exploring this aspect even though, at times, when a plant is suspected the real culprit may be an insecticide or a deodorizing household spray.

There has been considerable progress in public education by means of literature, lectures, and releases through various news media. Nevertheless, there is a constant influx of new residents and visitors who have no realization of the hazards, who naturally assume that plants commonly in evidence are harmless, and who readily adopt unsuspected harmful plants which are offered for sale—even in the produce sections of supermarkets. All need to be warned that there is much misinformation being circulated through lack of understanding or distorted hearsay. Because of the morbid or theatrical appeal of the very words, "poisonous plants," overeager amateurs and even well-meaning school children are playing the roles of authorities on the subject. Some efforts are constructive; others may do more harm than good. Exaggeration may be exciting but causes needless fear and makes the person who is later disillusioned less receptive to facts.

On the other hand, there are people who have knowledge of the hazards who choose to belittle or

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The Author

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She has conducted extensive field studies for the National Institutes of Health and the Department of Defense; has served as horticultural-development consultant in tropical America; participates in study panels of the Advisory Committee on Technology Innovation of the National Academy of Sciences and since 1954 has served as consultant for the Poison Control Centers of Florida.

ignore them, who consider themselves immune and feel no responsibility for the welfare of others. I have at times despaired of awakening the concern of individuals who are not moved by the distress of neighbors nor the plight of gardeners or telephone or power-company linemen whose activities require extreme contact with toxic or irritant plants. There are plant purveyors and professional landscapers who prefer not to admit, and even deny, the harmful aspects of plants which represent immediate profit regardless of consequences.

I have found that sometimes it is easier to arouse sympathy for animals than for people, and I have gained constructive attention by stressing the injuries to house pets and the perilous spread of some toxic ornamentals into horse pastures. Too, I have awakened some to a realization of the negative impact of toxic-plant invasion of wild areas and the consequent crowding out of native, beneficial vegetation. By laying stress on the now popular word "environment," I have been able to convey the message that with a growing human population each individual's personal environment — living space — is becoming smaller. We are being crowded into closer association with our ornamental and other plants and with our neighbors' plants. With increasingly congested highways, we will perforce be spending more free time at home in our individual plant/man relationship, and it behooves us to be sure that the plants we associate with are harmless. The shocking fact is that most of our harmful plants are cultivated plants introduced from other countries, and most instances of plant poisoning occur in and around the home. Home is where the poison is! This adds an unnecessary, avoidable hazard to those which fortuitously abound in most lives. There are far more nonpoisonous than poisonous plants available in Florida nurseries—many just as beautiful as (or even more attractive and desirable than) those which are capable of causing human and animal misery. We have a choice, and the right choice of safe planting material can contribute to greater pleasure in our gardens (indoors or out), greater peace of mind, less anxiety in parents, and will kindly and graciously improve the quality of life for ourselves, our neighbors, pets, and visitors.

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Poisonous Plants of Florida

Julia F. Morton, D.Sc.

Plant-poisoning—that is, plant-caused illness or injury—is an active problem in Florida 12 months of the year. There are numerous species throughout the state which could be classified as poisonous by virtue of possessing toxic constituents in one or more parts. However, only a limited number of plants, certainly under 200, are known to have actually caused bodily harm in this state, and less than 50 are responsible for most of the reactions which occur in children, adults or animals.

In my book, "Plants Poisonous to People," and companion Wall Charts of the same name, I have arranged the most important species in two groups, (1) Plants Causing Primarily Internal Poisoning; (2) Plants Causing Primarily Skin and Respiratory Irritation, in order to simplify identification of "culprits" for the general public.

Here, for a professional readership, I believe it is more useful to arrange common troublemakers by botanical family since related plants generally have similar properties and activity. The most prominent families with many well-known toxic members the world over are the Euphorbiaceae, Anacardiaceae, Solanaceae, Apocynaceae, Leguminosae, Araceae and Myrtaceae. These families are well represented among the plants affecting human health in Florida.*

EUPHORBIACEAE

The members of this family vary greatly in form —from succulent, cactus-like, grotesque trees, to low, creeping herbs. All secrete gummy sap (latex), usually white, acting as an irritant, powerful or moderate, externally and internally. The active principles in this sap have been identified as phorbol derivatives—diterpene esters. From these, Prof. Dr. E. Hecker, Director of the Biochemistry Institute of the German Center for Cancer Research, Heidelberg, has isolated a co-carcinogen, or tumor-promoting factor (TPA), which should cause us to view more seriously the human health hazard represented by the commercial exploitation of these easily grown and popular plants.

Euphorbia lactea Haw. FALSE CACTUS, "CANDELABRA CACTUS" [not even related to true cacti]. Native to the East Indies. A tree to 15 ft. tall with short, woody trunk and "candelabra" arrangement of green, succulent, usually 3-angled branches, the wavy angles bearing short, sharp spines. A common ornamental. Crested and fluted forms, curious monstrosities, sell at high prices.

Euphorbia tirucalli L. PENCIL TREE, MALABAR TREE, MILK BUSH, MONKEY FIDDLE. Native to Africa. A bushy tree, with many green, curving branches, bearing a profusion of slender, cylindrical, rubbery branchlets and twigs, with a few tiny leaves at their tips.

These two plants are foolishly planted close to houses and walkways, sometimes in foundation planters; eventually become too large and must be cut back. When cut or accidentally broken, they exude milky sap which is bitter and toxic internally. If allowed to remain on the skin it causes inflammation and sometimes blistering. In contact with the eye, it causes great pain, acute kerato-conjunctivitis, and temporary blindness. This is not at all an uncommon occurrence in Florida and one must assume that when the sap is exposed there are particles released into the atmosphere which irritate the eyes, or there would not be the almost inevitable rubbing of the eyes with contaminated fingers. Currently, there is much promotion of the pencil tree as a potted plant for indoor decoration and it is being propagated in quantity for shipment to other states. Recently, a man started to move a potted specimen in a library in Galveston, Texas. One of the twigs struck his eye, broke and leaked sap with resultant severe inflammation requiring emergency treatment.

Euphorbia cotinifolia L. RED SPURGE. Native to Central America and northern South America. A shrub or small tree, ultimately 10 to 25 ft. tall, with oval leaves ranging in color from dull-green to purplish-green, maroon or red, usually pale and often downy on the underside. It is well known as a source of severe dermatitis in its homeland, and the abundant sap blisters the mouths of grazing animals. It was introduced into the Florida nursery trade in 1959 and has given rise to rashes and

* Photographs 1 through 42, page 170a

blisters, depending on the degree of contact, and also eye inflammation. The seeds are violently purgative.

Euphorbia pulcherrima Willd. POINSETTIA. Native to Mexico. A shrub reaching 15 ft. in height but usually trimmed to 5 or 6 ft. or less. Its main leaves are green, more or less indented and up to 8 in. long. Floral leaves grouped in a showy rosette around the small green-and-yellow flowers are generally bright-red, sometimes pink or ivory-white. The 3-sided fruit, about ½ in. long, contains three purgative seeds. This universally beloved Christmas plant has become the subject of much controversy in recent years, the florist and nursery industry strongly protesting its classification as a toxic plant.

I am convinced that there is a great deal of variation in the potency of the sap in individual plants, and it is true that the strains especially developed and forced into bloom for the Christmas season contain much less milky sap than the older types which have been grown for years in dooryards. People repotting gift plants or trimming the garden poinsettias in summer and carrying loads of the cut branches in bare arms have certainly suffered blistering of the skin. Children in Florida have complained of burning in the mouth and throat from sucking a stem, leaf or flower-bud. In such cases, examination has shown acute inflammation. Licking a bit of the sap has caused oral and anal irritation. The Rochester, New York, Poison Control Center in 1965 informed me of a case of illness in a 2½-year-old child who had eaten a poinsettia leaf, and in 1976 the same Center reported that a 11-months-old infant sucked nectar from poinsettia flowers, was given ipecac and vomited three times in the next half-hour, passed dark, tarry stools for three days, and then the skin of her posterior, which had been inflamed, peeled off.

In all instances where reaction has occurred, the sap has been fresh. It is known to lose its toxicity on drying. Despite the opposition of poinsettia dealers, it is necessary to advise protecting the hands (preferably with disposable plastic gloves) when trimming poinsettias, avoiding eye contact with the sap, and keeping children away from the plants and cuttings.

Euphorbia milii Ch. des Moul. CROWN-OF-THORNS. Native to Madagascar. A low or climbing shrub with flexuous branches heavily clothed with spines and bearing paddle-shaped leaves to 2 in. long. Tiny flowers are flanked by two red, salmon-colored, or red-and-yellow petal-like bracts, giving the impression of a showy bloom ½ in. wide. Because of its thorniness, this plant is handled less than other ornamental **Euphorbia** species. Nevertheless, on occasion, the sap has caused severe dermatitis and punctures by the thorns have been so painful that persons so injured have sought relief in hospital Emergency Rooms.

Euphorbia heterophylla L. PAINTED LEAF or WILD POINSETTIA; **Euphorbia hirta** L., ASTHMA PLANT; **Euphorbia maculata** Small, SPOTTED SPURGE; as well as the closely related **Chamaesyce hypericifolia** Small and other herbaceous **Euphorbia** and **Chamaesyce** species, are among the most common weeds of lawns in Florida and are frequent causes of rash between the fingers and even overall rash in persons who have done much weeding without protective clothing.

Pedilanthus tithymaloides Poit. SLIPPER FLOWER, DEVIL'S BACKBONE or REDBIRD "CACTUS." Native to the West Indies and tropical America. A succulent, bushy plant to 4 or 5 ft. tall. Stems are thick, green, erect, zigzag, bearing stalkless leaves to 3 in. long, all-green or edged with white or often tinged with pink. The tiny flowers, borne at the tips of the stems in winter, are enclosed in tubular bracts which resemble tiny red slippers. The abundant sap has caused very painful eye inflammation and children have experienced burning in the mouth from biting into the plant. Actual ingestion of any part of the plant has induced vomiting and diarrhea. This plant is popular as a protective hedge in the Caribbean islands and is appearing more frequently in Florida with the influx of West Indian residents.

Jatropha curcas L. PHYSIC NUT. Native to the West Indies and tropical America. A small tree, to 20 ft. high, with thick branches bearing long-stemmed, 3- to 5-lobed leaves, to 8 in. wide, which are shed in winter. Small greenish flowers are borne in clusters in the spring and are followed by bunches of smooth, oval fruits about 1 in. in length which turn from green to yellow, then black. When the fleshy covering dries, it splits open disclosing the three black-skinned seeds. These are of agreeable flavor but contain a purgative oil more potent than castor oil, also the toxic protein jatrophin (or curcin) and a toxic resin. Unfortunately, this tree grows readily from seeds and cuttings and has been sold under the misleading names of "pistachio" and "Chinese peanut tree." Ingestion of the seeds has caused numerous instances of violent vomiting and diarrhea in Florida. Some individuals seem able to tolerate a few raw seeds or several roasted seeds without apparent ill effects, but they

run a grave risk for Dr. Hecker has found the seeds to be highly carcinogenic. The sticky yellow sap of the tree can cause skin and eye inflammation and is, of course, toxic internally. Latin Americans are accustomed to growing this and other toxic plants as hedges because roving stock do not eat them, and many have the custom of deliberately taking a physic nut or a castor bean or two as a purge. Therefore, they are apt to be indifferent to the health hazard.

Jatropha multifida. L. CORAL PLANT, erroneously called "NUTMEG TREE." Native from southwestern United States to northern South America. A spreading shrub or bushy tree to 20 ft. high with very ornamental leaves 6 to 12 in. broad, deeply divided into as many as 12 narrow segments. Small coral-red flowers are borne in long-stalked clusters. There is continuous year-around blooming and development of 3-sided fruits, to 1½ in. wide, which turn from green to yellow and fall to the ground. Each normal fruit contains three round, brown seeds about ½ in. wide. They are white within, of good flavor and have been eaten by children and adults in Florida with sad consequences — usually seven to eight hours of violent vomiting and diarrhea. This is a common ornamental and actively promoted in the nursery trade.

Jatropha gossypifolia L. BELLYACHE BUSH, erroneously called "AFRICAN COFFEE." Native to the West Indies and tropical America. A single-stemmed shrub to 6 ft. high, its upper branches bearing leaves as much as 6 in. wide deeply divided into 3 to 5 lobes. They range in color from all-green to green tinged with red or purple, or all-purple. The leaf margins, petioles and new shoots bear irritating hairs containing histamine. The flowers are small, dark-red, yellow-centered; the fruits, oval, ½ in. long, 6-ribbed, green until ripe, when they turn brown and each of the three sections splits open ejecting a small black or spotted seed. The seeds are toxic but cases of illness that have been brought to my attention have resulted from eating the whole green fruit.

Jatropha hastata Jacq. (**J. integerrima** Jacq.) PEREGRINA. Native to Cuba, Hispaniola and Puerto Rico. A small tree, to 15 ft. high, with slender, spreading branches and oblong, fiddle-shaped or irregularly lobed leaves to 6 in. long and bright-red (cerise) flowers 1 in. wide. The fruit is similar to that of **J. gossypifolia.** This is a very popular ornamental in Cuba and is becoming common in Florida. It is less of a hazard than the three preceding species because the ripe fruits explode, scattering the small seeds; also, it is generally taller than the Bellyache Bush and the unripe fruits less accessible to small children.

Ricinus communis L. CASTOR BEAN. Presumed native to tropical Africa. A large, tree-like shrub reaching 15 ft. or more in height. The long-stalked leaves, deeply divided into 7 to 9 pointed, toothed lobes, vary from 6 in. to 1½ ft. in width. They are bronze and silky when young, green or purplish-red when mature. Small yellow-and-red flowers are borne in upright spikes and develop into spiny fruits, light blue-green or bright-red when immature, becoming dry and brown and splitting open to release the shiny seeds — ¼ to ½ in. long and usually light-brown with dark-brown markings in Florida. Some seeds are entirely black or red or are white mottled with brown.

The seeds contain the familiar castor oil also the toxic protein ricin closely related to the potent abrin in the rosary pea and, besides, a powerful allergen (CBA). The seeds are of agreeable flavor, have been responsible for many cases of violent vomiting and purging in Florida, sometimes accompanied by burning in mouth, throat and abdomen, convulsions, hot skin, thirst and other symptoms. Respiratory distress and rhinitis may occur from proximity to the plant in bloom or from handling or wearing necklaces of the seeds, especially if a seed is broken. Sensitive people react to seed particles in the atmosphere so small as to be invisible to the unaided eye. This weedy, undesirable plant has been allowed to run wild extensively in Florida and has caused deaths in domestic animals and poultry.

Aleurites fordii Hemsl. TUNG NUT, from China, and **Aleurites trisperma** Blanco, LUMBANG NUT, from the Philippines. These are trees to 50 ft. or more with somewhat heart-shaped leaves to 1 ft. wide which are shed in winter. Sprays of small, whitish flowers appear before the new foliage in spring. The fruits are 2 to 3 in. long, greenish-brown and velvety. They split open when ripe disclosing 3 or 4 brown, chestnut-like seeds which are white within and of good flavor. Children and adults have been hospitalized after eating even less than one seed. The toxicity is attributed to diterpene esters which cause burning sensations from the mouth to the stomach, severe vomiting and diarrhea which begin in one half to one hour after ingestion and continue for six to seven hours or longer. The tung nut has been cultivated in groves around Gainesville; the lumbang nut as a shade tree in parks and parkways in southern Florida.

Hura crepitans L. SANDBOX. Native from the West Indies to Costa Rica and Bolivia. A tree to 60 ft., the trunk covered with short, conical spines. The broad-oval leaves to 9 in. long are downy beneath. Male flowers are dark-red, massed in a raspberry-like spike; the female flower suggests a small maroon mushroom. The fruit is a pumpkin-shaped, woody, ribbed pod 2 to 4 in. wide. It explodes when ripe, casting out the thin, flat, circular seeds, ¾ in. wide and brown-speckled. They contain a purgative oil and a toxic protein, hurin, much like curcin and abrin, which has recently been declared a potent lymphocite mitogen. The tree is grown as a curiosity in private and public grounds. Various instances of seed ingestion in Florida have resulted in abdominal pain, violent vomiting and diarrhea. The clear, sticky sap of the tree may cause intense skin inflammation.

Hippomane mancinella L. MANCHINEEL. Native to South Florida (mainly in the Cape Sable region) and the Keys, also the West Indies and tropical America. An erect, stout-trunked tree with pale gray bark and gummy white sap. The oval, pointed leaves are 2 to 4 in. long; the small flowers, yellow or rose, are borne in slender spikes to 6 in. long. Outwardly like a small apple, the fruit is 1½ to 2 in. across, green to yellowish, thin-fleshed, with a large woody stone containing small brown seeds. The toxicity of this tree has been greatly exaggerated. Eating the thin flesh of the fruit may cause sore tongue and mouth, abdominal pain and diarrhea, but some people have eaten several fruits with no ill effect. Contact with the sap has produced severe dermatitis in susceptible individuals and, in the eye, the sap will cause acute keratoconjunctivitis and acute pain as does the sap of our commonly cultivated **Euphorbia** species already described. Cases of injury are not common in Florida since the tree does not occur where there is much human activity. Several cases claimed to be manchineel poisoning were found to be caused by poisonwood which is far more abundant but much less publicized.

Cnidoscolus stimulosus Engelm. & Gray. TREAD-SOFTLY or SPURGE NETTLE. Native from southern Florida to Virginia and west to Texas. A common weed to 4 ft. high with slender green stems and 3- to 5-lobed leaves 3 in. to 1 ft. long. The white, 5-parted flowers are borne all year and are succeeded by bristly, 3-lobed fruits containing 3 toxic seeds. All above-ground parts of the plant are clothed with stinging hairs which produce instant burning and itching. The fiery sensation will subside in a half hour if not scratched, but rash or red eruptions may remain for several days. The starchy, tuberous root, which may descend several feet in coastal sand, is edible after boiling.

Codiaeum variegatum var. **pictum** Muell. Arg. "CROTON;" VARIEGATED LEAFCROTON. Native to Malaya. A shrub to 12 ft. high with short branches tipped with clusters of leathery leaves to 1 ft. long varying greatly in form and in color — from all-yellow or green to green-and-yellow, red-and-yellow, or dark-purplish-red-and-pink. The somewhat milky sap stains clothing. Despite the great popularity of this plant, much clipping and handling for decorative arrangements, few cases of dermatitis occur. Some people occasionally acquire a rash. Many times a child has chewed or swallowed a leaf with no ill effect. The dark-colored types may be acrid but the yellow types are nonirritant and edible.

ANACARDIACEAE

Toxicodendron radicans Kuntze. POISON IVY. Native in various forms over most of the United States except California, south to Guatemala; also in the northern Bahamas and Bermuda. A creeping or climbing vine with distinctly red stems and leaves divided into 3 leaflets, to 4 in. long, more or less irregularly toothed or lobed, and turning vivid red in winter. Small, yellowish flowers are borne in open clusters. The fruits are white, nearly round, ⅛ to ½ in. wide, with single, striped seeds which are distributed by birds. Accordingly, poison ivy often springs up in home yards, climbs up houses, fences, coconut palms, shade trees and power poles and thus is often encountered by humans who fail to recognize it, handle it, and suffer dreadful cases of dermatitis, with swelling, blistering and prolonged itching. It has been well established that poison ivy and its relatives cause two types of reactions — irritant and allergic. The toxic principle is reported as 3-**n**-pentadecetylcatechol with related factors. Reaction may be delayed several hours or two or three days. The poison contaminates shoes, clothing and tools and these may be sources of dermatitis months after contact. Also, smoke from the burning plant contains the poisonous material.

Toxicodendron vernix Kuntze. POISON SUMAC. Native from northern Florida to New Hampshire and west to the Great Lakes and Texas. A shrub or weak tree to 25 ft. high with compound leaves to 1 ft. long composed of 7 to 15 pointed leaflets. The midribs, leafstems and twigs are red and the sap watery. Small, greenish-yellow flowers are borne

in drooping sprays and are succeeded by whitish, often purple-streaked fruits which persist all winter after the leaves have fallen. Poison sumac occurs in damp flatwoods, on stream banks and in swamps as far south as Marion County in Florida but usually remote from human traffic and is not a common source of injury. Its effects are similar to those of poison ivy.

Metopium toxiferum Krug & Urb. POISONWOOD. Native to the Florida east coast from Martin County southward, Florida Keys, Bahamas, Cuba, Hispaniola, Puerto Rico, British Honduras and Yucatan. A tree, to 35 ft., with flaking bark, clear gummy sap which turns black on exposure, compound leaves having 3 to 7 glossy, oval leaflets to 4 in. long, purple when very young. Old leaves are often wind-damaged and bear black dots of dried sap. Small yellowish flowers and succeeding dull-yellow fruits are borne abundantly in dangling clusters — spring through summer. This is one of the commonest trees of southeastern Florida and a frequent cause of dermatitis, sometimes with extreme blistering, depending on the degree of contact. Reaction is usually delayed about 24 hours.

Schinus terebinthifolius Raddi. BRAZILIAN PEPPER, erroneously called "FLORIDA HOLLY." Native to Brazil. A bushy, spreading, fast-growing tree to 40 ft. high and equally wide. The compound, evergreen, aromatic leaves have red midribs and usually 5 to 9 oblong leaflets to 2 in. long. Sprays of tiny white flowers are produced copiously followed by masses of showy red, peppery fruits, 3/16 in. wide. Originally introduced and planted as a dooryard ornamental but seeds distributed by birds have given rise to extensive thickets of this aggressive "weed" tree over more than half the state of Florida and adjacent islands. Blooming occurs mainly in October-November but because of seedling variation some trees can be found in flower or fruit at any time of year. The pollen is not windborne, but when in bloom this tree is a source of widespread respiratory and skin irritation, and all-over rash in people who trim it or cut a single branch. Eye inflammation and facial swelling often occur. A calf suffered swelling of the head and hemorrhages in the eyes after eating leaves from an 8-ft. branch. Birds that indulge in the fruit excessively become intoxicated and unable to fly. Vigorous efforts are being made to awaken the public to the environmental impact of this tree and the need to eradicate it.

Mangifera indica L. MANGO. Native to southern Asia. A tree to 80 ft. or more with heavy trunk and branches and clear gummy sap. The evergreen leaves, borne in rosettes, are narrow and up to 15 in. long, wine-red, pink or yellowish when young. Tiny flowers, yellowish-white to reddish, are borne in massive, erect sprays from late November to February. Oval or elliptical fruits, 2 to 9 in. long, hang on long stems from May to September for there are early, medium and late varieties. As with poison ivy, there are irritant and allergic reactions to mango. Direct contact with the sap can cause blisters on the skin of most people. Some individuals are hypersensitive and react to contact with the sap, fruit peel or even the flesh of the ripe fruit with inflammation and swelling, especially of the face and eyelids and lips, often accompanied by rash around the mouth and itching. Proximity to the blooming tree may cause respiratory distress, itching of the eyes and facial rash. The old, fading flowers give off a rank, offensive odor.

Anacardium occidentale L. CASHEW. Native to northeastern Brazil and southern Venezuela. A bushy, spreading tree to 35 or 40 ft. in height and width, with evergreen, leathery leaves to 8 in. long, small, fragrant, yellow-pink flowers in loose terminal sprays to 10 in. long. The conspicuous false-fruit, or "cashew apple," is pear-shaped, 2 to 4½ in. long, waxy, red or yellow, fleshy and very juicy. Actually, it is a swollen fruit stalk at the tip of which is the true fruit, the cashew nut, shaped like a boxing glove. The cashew apple is very astringent and fibrous but much sucked for its juice and it is also cooked in sirup and eaten. Between the two layers of the cashew nut shell there are cells containing copious caustic resin which causes extreme inflammation and blistering on contact.

There are a number of fruiting cashew trees in South Florida. Unwary persons who have bitten into a raw cashew nut have suffered great swelling of the face and lips, with blistering, later blackening and peeling. A few years ago, I was to appear as a witness in a Washington, D.C. court on behalf of a lady who had cut open and eaten the kernels of raw cashews she had obtained from an importer's display in a supermarket. Her external and internal injuries were severe and prolonged and, finally, the case was settled in her favor out of court. I always advise inquirers not to attempt to home-roast the nuts in order to gain the kernel. The smoke from crude open-fire roasting is very irritating and handling and opening the nuts after roasting is risky. Commercially, cashews are "roasted" (boiled) in a bath of their own oil to rupture the cells and force out the poisonous oil before they are opened.

There are various steps in the process, too elaborate for the amateur. Even after the most skillful processing, cashew kernels may still be sufficiently contaminated by CNSL (cashew nut shell liquid) to cause oral and anal itching in people who buy the so-called "raw" kernels in health food stores. As imported into this country in tins, the kernels should go to the factories for roasting (and usually salting) before they are offered for sale and most of them are thus decontaminated.

CNSL has many industrial applications, being highly heat and friction resistant, but when it was first adopted into use in factories and machine shops in this country, it caused much dermatitis in mechanics and other workmen and processes had to be developed to detoxify it. It is now in great demand as a versatile natural phenol.

SOLANACEAE

Cestrum diurnum L. DAY JESSAMINE. Native to the West Indies. A shrub or small tree to 15 ft. high with smooth, thin, evergreen leaves to 6 in. long. Throughout the year it bears a succession of small, tubular white flowers in great profusion, quickly followed by heavy crops of berries which turn from lavender to dark-purple, contain purple juice and minute black seeds. Children and pets, after eating the fruits in quantity, have displayed the effects of an atropine-like toxin—salivation, labored respiration, rapid heartbeat, high temperature, lack of muscular control, partial paralysis and hallucinations, with or without dilated pupils. Birds have distributed the seeds far and wide and the day jessamine has become a major pest in pastures. Investigations have revealed that the leaves contain 1.25-dihydroxy vitamin D_3-glycoside which induces excessive deposits of calcium in the heart, liver, kidneys and other organs of grazing animals. It is apparently the cause of painful and fatal hypercalcemia and calcinosis in Florida horses and cattle.

Cestrum nocturnum L. NIGHT-BLOOMING JESSAMINE. Native to Mexico, Central America and the West Indies. A shrub to 12 ft. high with numerous, slender arching branches bearing evergreen, oblong leaves to 8 in. long and an abundance of white, tubular flowers to 1 in. long which open at night. Blooming occurs several times a year and the heavy, far-reaching odor causes respiratory distress and illness in many people. Effects include difficulty in breathing, depression, uneasiness, intense headache, nausea, dizziness, throat irritation, and sneezing. This shrub was introduced at least 100 years ago and has been cultivated throughout Florida as a dooryard ornamental. It does not fruit as heavily as **C. diurnum;** the fruit is white, about ½ in. long and reportedly toxic. On occasion, Florida children have ingested a few fruits, their stomachs have been emptied, and there have been no signs of illness. Cattle in Africa and Australia have died from grazing on the leaves but, fortunately, this species has not run wild in South Florida.

Datura candida Pasq., **D. mollis** Safford and **D. suaveolens** H. & B. ANGEL'S TRUMPETS. Native to tropical America. These are small trees to 15 ft. with drooping, downy leaves to 15 in long. The flowers, 8 to 12 in. long, resemble trumpets. Those of **D. candida** (white) and **D. mollis** (peach or salmon-colored) hang straight down; those of **D. suaveolens** hang at an angle. Seedpods are not produced in our climate. The heavy, sweet emanation from the flowers causes violent headache, nausea, dizziness, and even stupor on close proximity. Eating a whole or part of a flower produces symptoms typical of atropine poisoning: dilated pupils, dryness and burning in the mouth, difficulty in swallowing, excitement, hallucination, drowsiness, weakness, fever with cold extremities, incoordination, muscular and respiratory paralysis. Serious cases from accidental or deliberate ingestion have occurred in Florida.

Datura metel L. and **D. stramonium** L. DEVIL'S TRUMPET and JIMSONWEED. Of uncertain origin, widely cultivated and naturalized in both hemispheres. Shrublike annual herbs to 4 or 5 ft. tall. Stems are green or dark-purple. Leaves are unpleasantly odoriferous, downy, ½ to 1 ft. long. The trumpet-like flowers, single or double, to 8 in. long, point upward at an angle. The abundant, spiny seedpods are rounded and face downward in **D. metel;** are pointed and erect in **D. stramonium.** They split open when ripe and dry, releasing glossy brown seeds. Severe atropine-type reactions have resulted from deliberate or accidental ingestion of flowers, seedpods or seeds in Florida as in many other parts of the world. These and other species of **Datura** are notorious for their toxicity and have been much employed for malicious poisoning.

Solandra nitida Zucc. CHALICE VINE. Native to Mexico. A climbing shrub with broad-oval leaves to 6 in. long, downy beneath. The flowers to 9 in. long are formed like long-stemmed goblets, are ivory-white at first and gradually turn a rich yellow. They are very fragrant at night. The rounded white fruit to 2½ in. wide is nontoxic. All other parts, sap, foliage and flowers, contain the poison solan-

drine which is similar to atropine in action. The odor of the flowers has caused headache, nausea and dizziness. Accidental or deliberate ingestion of the flowers or of a 'tea" made from them results in violent intoxication, dilated pupils, numbness of hands and feet and delusions. This is the most common winter-blooming "vine" in Florida, the season extending from fall to late spring.

APOCYNACEAE

Nerium oleander L. OLEANDER. ADELFA in Cuba. Native to Asia. A multiple-stemmed shrub to 20 ft. high with stiff, slender leaves to 8 in. long and terminal clusters of somewhat bell-shaped, 5-parted flowers—white, pink or red—appearing in spring and continuing until fall. The slim, cylindrical seedpods split open on maturity and release small, hair-tipped seeds. All parts of the plant contain toxic glycosides, especially neriin and oleandrin which resemble digitalis in action.

Oleander is commonly cultivated throughout Florida and has many loyal defenders despite its well-recognized toxicity. Numerous cows, horses and other animals in Florida have died from grazing on oleander, less than 1 oz. of leaves being a fatal dose for a horse. Contrary to rumors, we have had, as far as I know, no human deaths from oleander in Florida, though there was one nearly successful suicide attempt from drinking an infusion of 12 leaves. Several other cases of slight poisoning from partly chewing a leaf, flower, or oleander cuttings. or licking the sticky sap have certainly occurred. The sweet, heavy emanation from the flowers has caused nausea and dizziness. One man suffered acute headache, high blood pressure and irregular heartbeat after trimming the dead wood from six oleander bushes. Particles of sap released into the air were unquestionably inhaled and swallowed during the trimming operation. Some individuals acquire dermatitis from oleander but this is not a common complaint. Smoke from burning oleander is highly toxic and has caused serious illness in firemen and others in Florida.

Allamanda cathartica L. YELLOW ALLAMANDA. Native to Brazil. A climbing shrub with evergreen, elliptic leaves arranged in whorls of 3 or 4 spaced along the stems. Conspicuous and profuse bell-shaped yellow flowers, 3 to 5 in. wide, are present from spring to late fall and the yellow allamanda is one of our most popular ornamentals. I reluctantly include it among poisonous plants because there have been only mild and occasional reactions from the sap—such as oral irritation and slight nausea from prolonged sucking of cut stems, rash from wiping the sap on sensitive skin, and one report of burning inflammation from getting the sap in the eye. The plant has been given a bad reputation because of the drastic consequences of ingesting a quantity of the sap as a purgative in tropical American folk-medicine.

LEGUMINOSAE

Abrus precatorius L. ROSARY PEA, JEQUIRITY BEAN, CRAB'S EYES. Native to India, widely introduced and naturalized in most warm climates. A slender, high-climbing vine with feathery, licorice-flavored leaves to 4 in. long and pea-like, white to pinkish flowers borne in clusters in the fall. The seedpod to 1½ in. long is produced in bunches of a few to more than 20 in early winter. The pods are green at first and contain 3 to 8 oval seeds ¼ in. long, tender, easily crushed when immature, pink with black tip. As the pods ripen and dry, they burst open and the seeds are then slightly smaller, brilliant-red, black at one end, and very hard. Whether soft or hard, fresh or several years old, the seeds are exceedingly dangerous, containing the very toxic protein abrin. Birds distribute the seeds and this vine is an aggressive and common weed throughout Florida.

Children often play with the handsome dry seeds and use them in peashooters. If hard and unbroken, seeds may be swallowed and will pass through the system without harm. However, if hard seeds are pierced (as for stringing in necklaces), cracked or actually chewed, one seed or less will cause intense poisoning. There have been several fatalities in very young children in Florida, especially from ingesting the soft, unripe, easily chewable seeds. One adult suicide resulted from grinding up mature, hard seeds. A few teenagers who have ingested broken or chewed mature seeds have been hospitalized with severe and prolonged vomiting and diarrhea, cold perspiration, and rectal bleeding. The latter may persist for months. Abrin is a delayed-action poison and outward signs of illness may not occur for several hours or even two or three days, depending on the age of the victim and amount ingested. In fatal cases, acute gastroenteritis may prevail for several days before death. Several horses have died from rosary pea poisoning, for the vine is all too common on and near neglected pasture fences.

ARACEAE

Plants of this family, called "aroids," are among the most popular of foliage plants widely grown

indoors and common outdoors in Florida. All possess copious watery sap with irritant properties, some species more toxic than others. Contact with the sap generally causes an itching rash. Biting or chewing stems or leaves of these plants produces inflammation of the mouth and tongue, swollen lips, blisters in the throat, and internal inflammation if the juice is swallowed. Lime juice is an effective antidote. Human injury from contact with aroids is common. Sometimes older children, as a prank, induce younger brothers or sisters to take a bite because of the instant burning effect. Often cats or dogs seeking attention or left alone in the house suffer the consequences of biting into aroids and some become quite distrustful of their owners afterwards.

Dieffenbachia maculata Bunting (formerly **D. picta** Lodd.). DUMB CANE. Possibly native to Brazil. A common plant with succulent, thick stem and variegated leaves to 15 in. long; has especially acrid sap and is a frequent cause of injury. This plant is vigorous and when it grows too tall people generally make cuttings of the excess stem for propagation. The juice may severely inflame the hands and arms and if accidentally conveyed to the mouth (as when smoking) causes acute misery. The sap, which of course is under pressure in the tissues of the unbroken plant, apparently is released in invisible jets into the atmosphere and inhaled, for people have experienced respiratory irritation after making cuttings of **Dieffenbachia.** Any other species of this genus will have the same effects.

Xanthosoma spp. ELEPHANT'S EAR, COCO-YAM, MALANGA, YAUTIA. Native to tropical America. These herbs, with large arrowhead-shaped leaf blades 1 to 4 ft. long held horizontally or pointing downward have long been dooryard plants. The ornamental species (usually **X. jacquinii** Schott) has the irritant watery sap common to all aroids and its tuberous root is very acrid. Elephant ear's are common causes of child or pet injury through biting or chewing a leaf or stem. Now, with the commercial cultivation of the edible-rooted **X. caracu** Koch & Bouche in South Florida which is difficult to distinguish from the ornamental species, people are apt to try to eat the root of the wrong plant. One lady had her husband dig up and cut off the thick root of the elephant's ear in their yard. When he peeled it for her, it irritated his hands and she, therefore, decided to boil it twice, discarding the first water. She did so, then tasted a teaspoonful to judge how to season it for serving. Only half the amount in the spoon was taken into her mouth and swallowed but it caused burning in her mouth, throat and esophagus and she had not entirely recovered from the experience when she last reported to me two weeks later.

Alocasia macrorrhiza Schott. GIANT ELEPHANT'S EAR. Native to southern Asia. This plant, with more rounded leaf blades pointing upward and often blotched with white, is somewhat less common than **Xanthosoma** but nevertheless a source of injury. The sap and the rhizome are very acrid.

Philodendron selloum C. Koch. Native to tropical America. This common "self-heading" **Philodendron** of Florida dooryards has a thick, erect stem with supporting aerial roots and deeply cut leaves to 3½ ft. long. It is seldom suspected but often the cause of itching rash from contact with the watery juice. Other species of **Philodendron** may be sources of dermatitis or oral inflammation in children.

Rhaphidophora aurea Birdsey (formerly known as **Scindapsus aureus** Engl., or **Pothos aureus** Lind.). HUNTER'S ROBE. Native to the Solomon Islands. A climbing plant with strong stem bearing aerial roots. Leaves are heart-shaped, small on potted specimens, become 1½ ft. wide if the vine is planted out and allowed to climb trees. The sap is a frequent cause of dermatitis especially when cuttings are made for propagation.

MYRTACEAE

Melaleuca quinquenervia S. T. Blake. CAJEPUT, PUNK TREE or PAPER-BARK. Native to Australia. An upright, slender tree to 80 ft. or more, the trunk and branches clothed with layers of whitish papery bark which peels off in shaggy flakes. The evergreen leaves are stiff, narrow, pointed, 2 to 8 in. long, and very aromatic. Flowers, white with prominent stamens, are borne in "bottlebrush" spikes 1½ to 6 in. long. The main flowering season is October-November, a second widespread bloom taking place in June-July. However, individual trees may burst into flower at other times of year and the summer blooming season may extend until fall if there are alternate rainy and sunny spells. Seeds, fine as dust, are enclosed in numerous rounded capsules massed along the twigs.

This fast-growing tree was deliberately introduced into Florida by Dr. John Gifford of Miami in 1906 and Allen Andrews of Estero in 1912 for the specific purpose of drying up the Everglades which these enthusiasts considered a "useless swamp." They had the seeds sown by airplane over the 'Glades; they germinated readily in water and seed-

lings soon sprang up in great numbers crowding out native vegetation and forming solid stands over large areas. The tree has become a major pest throughout much of South Florida, has replaced native trees and shrubs on which wildlife has depended for forage and it provides no food for birds or 4-footed animals.

Nurserymen and landscapers over the years have taken advantage of this cheap wild source of trees and have planted the cajeput mainly as a foundation tree close to homes, apartment houses and other buildings. It can usually be found right outside a window. Very little pollen is airborne but a far-reaching odoriferous and irritant substance is dispersed into the atmosphere when the tree is in bloom. I receive pathetic calls from people who suffer misery—difficulty in breathing, nasal and sinus congestion, sneezing, throat irritation, coughing, burning of the eyes, swollen eyelids, facial inflammation and sometimes rash. People who have been overexposed to the blooming tree may react to the presence of the tree when there are no flowers but when there is a new flush of leafy growth.

In recent years, the problem has become a very serious one because full-grown trees are being brought in from the Everglades by the hundreds and planted around new condominiums. These developments are occupied mainly by retired people many of whom already have emphysema or other respiratory problems or cardiac difficulties. Suddenly they find their conditions worsened and investigation shows that this situation coincides with the blooming of the trees close to their habitations. What has been happening on a lesser scale in the past is occurring wholesale today, and retirees find themselves trapped in an intolerable environment. Then there are the asthmatic children who are brought to South Florida as an escape from northern pollens, sometimes at great economic cost to the parents. Proximity to the cajeput has greatly aggravated the complaints of such youngsters and, in many cases, years have gone by before the cause of increased difficulty has been recognized. This tree affects so many people that it can truly be called "Public Enemy #1." Concerned citizens and some state agencies are making efforts to halt its invasion of our natural areas and prevent its continued use as a landscape tree.

For information on other plants which occasionally cause illness or injury in humans in Florida consult "Plants Poisonous To People,"* also the circular, "Poisonous Plants Around the Home," of the University of Florida's Agricultural Extension Service, and literature distributed by the State of Florida's Department of Health and Rehabilitative Services.

▶ Dr. Morton, University of Miami, P.O. Box 248204, Coral Gables 33124.

* Published by Fairchild Tropical Garden, Coral Gables, Fla.



1. **Candelabra Cactus**
Euphorbia lactea



2. **Pencil Tree**
Euphorbia tirucalli



3. **Red Spurge**
Euphorbia cotinifolia



4. **Poinsettia**
Euphorbia pulcherrima



5. **Crown-of-Thorns**
Euphorbia milii



6. **Wild Poinsettia**
Euphorbia heterophylla



7. **Asthma Plant**
Euphorbia hirta



8. **Slipper Flower**
Pedilanthus tithymaloides



9. **Physic Nut**
Jatropha curcas



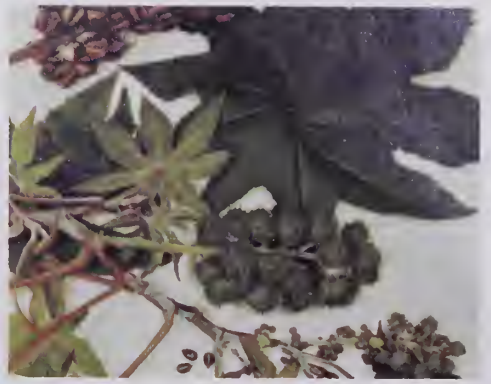
10. **Coral Plant**
Jatropha multifida



11. **Bellyache Bush**
Jatropha gossypifolia



12. **Peregrina**
Jatropha hastata



13. **Castor Bean**
Ricinus communis



14. **Lumbang Nut**
Aleurites trisperma



15. **Sandbox**
Hura crepitans



16. **Manchineel**
Hippomane mancinella



17. **Tread-Softly**
Cnidoscolus stimulosus



18. Croton



19. Poison Ivy



20. **Poison Sumac**



21. Poisonwood
Metopium toxiferum



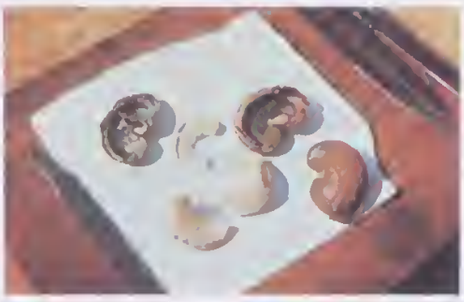
22. Brazilian Pepper
Schinus terebinthifolius



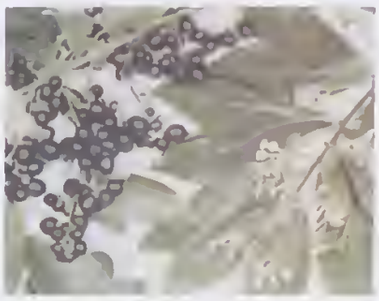
23 Mango
Mangifera indica



24 Cashew
Anacardium occidentale



25. Cashew (Nuts)
Anacardium occidentale



26. Day Jessamine
Cestrum diurnum



27. Night-Blooming Jessamine
Cestrum nocturnum



28. Angel's Trumpet
Datura candida



29. Angel's Trumpet
Datura mollis



30. Devil's Trumpet
Datura metel



31. Jimsonweed
Datura stramonium



32. Chalice Vine
Solandra nitida



33. Oleander
Nerium oleander



34. Yellow Allamanda
Allamanda cathartica



35. Rosary Pea
Abrus precatorius



36. Dumb Cane
Dieffenbachia maculata



37. Elephant's Ear
Xanthosoma jacquinii



38. Elephant's Ear
Xanthosoma caracu



39. Giant Elephant's Ear
Alocasia macrorrhiza



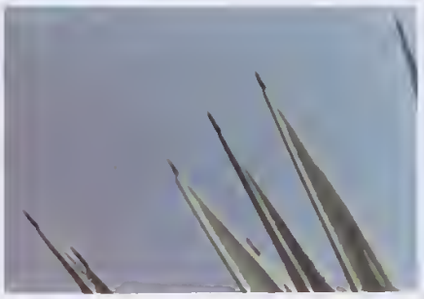
40. Philodendron
Philodendron selloum



41. Hunter's Role
Rhaphidophora aurea



42. Melaleuca
Melaleuca quinquenervia



43. Century Plant
Agave angustifolio marginata



44 Century Plant
Agave franosinii



45. Century Plant
Agave americana



46. Cathedral Cactus
Cereus spp.



47. Cathedral Cactus
Cereus spp.



48. Spanish Bayonet
Yucca aloifolia



49. Pigmy Date Palm
Phoenix roebelenii



50. Aloe
Aloe spp.



51. Ponderosa Lemon
Citrus spp.



52. Lemon
Citrus spp.



53. Orange
Citrus spp.



54. Bush Palmetto
Sabal minor



55. Acute allergic contact dermatitis due to poison ivy. Eczematous lesion of forehead



56. Acute allergic dematitis due to poison ivy of arm. Eczematous lesions with scratch marks probably due to plants



57. Acute allergic contact dermatitis due to poison ivy. Linear lesions.



58. Acute allergic contact dermatitis due to poison ivy. Vesicular lesions.

Pharmacology of Poisonous Plants of Florida

Kenneth F. Lampe, Ph.D.

Abstract: The active principals of poisonous plants found in Florida are discussed. Abrin and ricin are the most toxic substances of plant origin.

The toxic flora of Florida is so abundant and varied that it is only possible to present a few examples in this article. These have been selected on the basis of high frequency of poisoning potential, seriousness of the poisoning, or for some unusual features which might not be predicted from the pharmacology of a pure toxin. Within the first of these categories, frequency of poisoning, the belladonna containing plants Jimsonweed **(Datura stramonium)** and Angel's Trumpet **(D. candida, D. metel)** were omitted because they are discussed elsewhere in this issue.

A cardinal element in emergency room therapy of plant poisoning, in the absence of previous vomiting, is to evacuate the stomach by induced emesis (not lavage) and then to instill a slurry of activated charcoal in water. Neither induced emesis nor activated charcoal, in the experience of many major poison control centers, have ever been associated with morbidity and they serve to reduce continuing absorption of plant toxins. It should be noted that almost every systemically toxic plant, regardless of the essential pharmacology, produces emesis and/or diarrhea as one of its effects. Therefore, another essential step to successful management, particularly in the young child, is careful attention to the state of hydration and electrolyte balance. Only rarely is a specific therapy indicated; in most instances only symptomatic care is desirable. The cliche, "Treat the Patient, Not the Poison," is nowhere more evident as appropriate advice than in plant poisoning.

Photographs of toxic plants not shown in this issue can be found in the books by Hardin and Arena[1] and Morton.[2] Monographic treatments of the botanical and medical aspects of toxic plants with extensive bibliographies are given by Kingsbury[3] and Lampe and Fagerstrom.[4]

Dieffenbachia

The most recently available statistics from the National Clearinghouse for Poison Control Centers show **Dieffenbachia** as the genus most commonly associated with plant ingestions producing symptoms leading to emergency room visits. Most members of the botanical family Araceae to which the Dieffenbachia (Dumb Cane), **Caladium, Monstera** (Ceriman), **Alocasia, Colocasia** (Elephant's Ear), **Xanthosoma** (Malanga), and **Philodendron** belong contain water insoluble calcium oxalate in bundles of fine, needle-like crystals packed in specialized cells. Bundles of this character, called raphides, are found in all parts of the plant: roots, stems, leaves, spadices and fruit. The raphides have the property of ejecting the needles when the plant is chewed producing a painful burning sensation in the mouth. Various other irritants may also be present including glucosylbenzaldehydes which would hydrolyze into phenolic substances and possibly proteinaceous substances. The various genera previously listed are not equivalently irritating nor are even the various species of **Dieffenbachia,** although these are the most irritant of the Araceae grown in the United States.

Almost immediately after chewing the stem or leaves of a **Dieffenbachia** an intense burning sensation is felt in the mouth accompanied by increased salivation. The buccal mucosa, tongue, and palate become edematous and bullae may form. The speech becomes thick and unintelligible, hence the common name Dumb Cane. In small children the edema may become so severe that maintenance of airway becomes difficult and tracheostomy may be required. Treatment is essentially symptomatic. The edema in severe reactions begins to lessen within about four days, but the pain regresses more slowly. Superficial necrosis may be anticipated on the tongue and buccal mucosa.

Entry to the plant juices into the eye produces considerable pain and reversible corneal injury. The use of disodium EDTA to remove the calcium oxalate needles from the eye has been described.

Pokeweed

If it were grown as a house plant, the species which could probably topple **Dieffenbachia** from its preeminence in irritant poisonings is the Pokeweed **(Phytolacca americana).** Ingestion of the unripe berries, roots, or uncooked leaves of this plant, also known as Inkberry, Pigeonberry, or simply as Poke, causes a transient feeling of warmth and a bitter taste in the mouth but its primary effect is delayed for about two hours. Presumably this latent period represents the delay necessitated for hydrolysis of the triterpenoid acids to their active forms, phytolaccagenic (the major component) and phytolaccic acids. The intoxication begins with a general feeling of lassitude. This is followed shortly by a soreness in the mouth and throat with increased salivation, coughing or throat clearing, and thirst. A prodroma of warmth in the throat and stomach usually precedes nausea, severe gastric and intestinal cramping, persistent vomiting and diarrhea. In severe intoxications, tremors may develop. There is profuse perspiration, salivation, and occasional cardiac arrhythmias. Therapy is directed toward allaying the abdominal pain and preventive measures against the development of dehydration. Symptoms resolve in about 24 hours.

Intoxications from Pokeweed have resulted from misidentification of the roots for parsnips or horseradish. The unripe berries are slightly toxic but, when ripe, are edible. Pokeweed greens are sold in many southern markets and have produced poisonings in families who were unaware that "Poke Salad" refers to a dish for which the leaves and stems are boiled and the pot water containing the toxic material is discarded. Recently, a potential second type of toxicity to Pokeweed has been recognized. Children who have eaten the unripe berry or individuals who have absorbed plant juices through cuts and abrasions in the skin show peripheral blood plasmacytosis in response to a lectin (phytohemoagglutinin) present in Pokeweed. Although not yet evaluated, it does suggest that precaution in the form of gloves and protective clothing is indicated in handling this plant.

The Author

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Chalice Vines, Ground Cherries, and Nightshades

The members of this group all belong to the botanical family Solanaceae which is composed of 75 genera. Not all of these genera contain toxic plants, but some which do, for example **Solanum,** contain over a 1,000 individual species. Any given species may show a wide variability in toxicity due to genetic variation, growing conditions, exposure to light, the plant part ingested, and its maturity. Certain berries, for example the Ground Cherry (**Physalis** spp) and the Black Nightshade **(Solanum nigrum),** are poisonous when green and harmless when ripe, whereas others such as the Jessamines (**Cestrum** spp) produce solanine poisoning when green and belladonna poisoning when mature. Indeed, many of these plants, particularly the Chalice Vines (**Solandra** spp), contain variable amounts of the solanine glycoalkaloids and belladonna-like alkaloids giving unpredictable, mixed intoxications.

The toxic principles are a number of glycoalkaloids collectively called solanines. Hydrolysis cleaves the solanine compounds into sugars and one of several steroidal alkaloids (alkamines). The intact solanines act as gastroenteric irritants, whereas the alkamines are responsible for systemic effects.

Some hours after ingestion a harsh, scratchy feeling develops in the mouth and oropharynx. This is followed by nausea, emesis, abdominal cramps, and diarrhea. An increased body temperature is common and thus the intoxication may be confused with bacterial gastroenteritis. It should be remembered that additional symptoms related to the belladonna alkaloids may appear. Systemic involvement from the alkamines is uncommon, particularly in adults, and is usually limited to a feeling of weakness, apathy and headache. Solanine has a relatively low toxicity, although some fatalities were noted recently in Maryland from ingestion of the berries of the Horsenettle **(Solanum carolinense)** which is found in northern Florida. Usually, however, recovery is uneventful.

Wisteria

The pharmacologically active ingredients contained in the various species of **Wisteria** have not been identified. A mitogenic lectin has been characterized but this is not the active toxicant encountered following ingestion. Poisoning is most often seen in children from eating the beans or whole pods of the Wisteria vine. One or two of the beans are usually sufficient to produce a response. The flowers are not toxic.

The predominant effect is gastric irritation evidenced by nausea, abdominal pain, and repeated emesis. Abdominal distension may occur but diarrhea is usually absent or minimal. Whether this indicates a toxin that is destroyed by the alkalinity of the intestine or that the toxin is only a centrally acting emetic has not been investigated. No fatalities have ever been reported and despite the severity of the intoxication the patient usually becomes asymptomatic within 24 to 48 hours. An antiemetic may reduce distress. Appropriate attention should be directed toward preventing dehydration.

Tung Nut

Several investigators have worked on the toxic principles of the Tung Oil tree **(Aleurites fordii)** but their chemistry is still unknown. Only the kernels are poisonous; the bark, nutshell, and oil, although capable of producing contact dermatitis, have no systemic toxicity. The kernels of the Candlenut Tree **(A. moluccana)** and of the Lumbang Nut **(A. trisperma)** have similar effects, but the concentration of toxin in the Candlenut is apparently much less than the kernels of the other two.

Poisoning has occurred after ingestion of the kernels of only one nut, however, the usual intoxicating dose is three or more nuts. About 20 to 40 minutes later, the victim experiences a brief period of nausea and a burning sensation followed by persistent vomiting, severe abdominal cramps, and profuse diarrhea with tenesmus. Other symptoms which have been reported may be attributed, for the most part, to the rapid development of a profound degree of dehydration.

The violent emesis usually serves to remove the bulk of ingested material from the stomach. Except in severe cases, the patient requires only symptomatic support and reassurance. Dehydration should, of course, be prevented. Generally the patient become asymptomatic in about 12 to 24 hours.

Rosary Pea and Castor Bean

Abrin and ricin, which are contained respectively in the seeds of the Rosary Pea **(Abrus precatorius)** and Castor Bean **(Ricinus communis)** are the most toxic substances of plant origin known. Their IP LD_{50} in mice is 40 and 100 nanograms. The estimated oral lethal dose in man is 0.1 mg/kg and 0.5 mg/kg respectively. Human poisoning is characterized by a latent period of many hours to days, followed by severe gastroenteritis and necrosis of the gastroenteric tract. Occasionally systemic involvement of the liver, kidney, and spleen may occur. (See additional details in case histories given by Dr. J. Davis elsewhere in this issue).

There are two types of protein in the seeds of these plants, a nontoxic lectin (hemoagglutinin) and an extremely toxic glycoprotein, which has only a trace of agglutinating property. The glycoprotein, which was formerly known as toxalbumin, has a molecular weight of 60,000 to 65,000 and is composed of two chains, labeled A and B, which are joined by a disulfide bond. The nontoxic B chain contains most of the carbohydrate. This chain binds the whole toxin to the cell surface by attaching to galactose-containing receptors. After binding, the toxic A chain is transported into the cytoplasm by endocytosis. This is a slow process which may be, in part, responsible for the prolonged latent period. The ultimate site of action is the ribosome where the toxin acts to prevent protein synthesis by inhibiting elongation of the peptide chain.

No treatment other than aggressive supportive care is known. Severe intoxications almost invariably end with death. Fortunately, various factors combine to reduce poisoning. In both plants the seed coats are very hard, so if the seeds are swallowed whole there is usually no clinically significant effect. In the case of the castor bean, other substances present induce vomiting and catharsis which serve to limit absorption. Finally, a considerable portion of the toxins are apparently destroyed by the digestive enzymes.

Although little studied as yet, it is thought that similar toxins may underlie poisoning by certain other plants found in Florida. These include the various species of **Jatropha** (Coral Plant, Physic Nut, Peregrina), **Hura crepitans** (Sandbox Tree, Monkey Pistol), **Robinia pseudoacacia** (Black Locust), and, in trace quantities, Momordica charantia (Balsam Pear).

Carolina Yellow Jessamine

Although long recognized as a potentially toxic plant due to numerous instances of poisoning which occurred during medical use of an extract of the plant for neuralgia around 1900, actual incidents of poisoning due to the Carolina Yellow Jessamine **(Gelsemium sempervirens)** are relatively infrequent and are generally associated with children chewing on the flowers. The toxicity is due to a number of pharmacologically related alkaloids, most importantly gelsemine and gelsemicine. The symptoms tend to be dramatic and neurologically complex. These include headache, dizziness, blurring of vision,

mydriasis, ptosis, dry mouth with accompanying dysphagia and inability to enunciate. In more severe cases, the patient may exhibit more pronounced signs of muscular weakness besides ptosis, which is invariably present, such as double vision and relaxation of the jaw. However, there may be signs of a weak strychnine-like effect causing intermittent periods of muscular rigidity, particularly trismus. Dyspnea and breathing irregularities of various forms may be present. Sometimes consciousness is lost. The clinical management is symptomatic with airway management and respiratory support as indicated. The intoxication from minor exposure usually resolves within 24 hours with the exception of the visual disturbances which may persist for several days.

Water Hemlock

The Water Hemlock **(Cicuta maculata var. curtissii)**, also known as Spotted Cowbana, may be found in wet, swampy areas of northern Florida. Many poisonings occur from eating the tuberous roots in the belief that they are "wild parsnips" since the yellow, oily sap from this plant has a pronounced parsnip-like odor. Within 15 minutes or so, the victim experiences nausea, salivation, and emesis, followed almost immediately by tremors then tonic-clonic convulsions. The active ingredient, cicutoxin, is an unsaturated, 17 carbon, aliphatic alcohol. Its action is relatively transitory, so if the patient survives the period of status, he is usually asymptomatic other than for the usual confusion and retrograde amnesia of the event. Treatment, if it can be obtained during the seizure period, depends upon evaluation of the severity of the seizures, protection against bodily injury, airway support, and diazepam (Valium) or other short-term anticonvulsant.

Delphiniums and Larkspurs

Poisoning by the cultivated Delphinium and Larkspurs (**Delphinium** spp) may occur by ingestion of any part of the plant, but the roots and leaves contain the highest quantity of toxin. The alkaloids in these plants are members of the ajacine group which are toxicologically related to aconitine.

The initial symptoms, which occur in a few minutes, are a tingling and burning sensation of the lips, tongue and mouth followed by numbness. A similar effect is perceived in the throat, which develops a feeling of constriction, accompanied by dysphagia and difficulty with enunciation. The distinctive diagnostic feature is skin paresthesia which begins with a tingling and develops most intensively in the face along the distribution of the trigeminal nerve and formication in the extremities, usually the fingers. A number of other symptoms may develop: apprehension, confusion, intense headache, muscular weakness, muscular fasciculations, dyspnea, and convulsions.

Death, which usually occurs within one to six hours, is secondary to ventricular fibrillation. Usually an initial tachycardia may be observed followed by cardiac slowing and a variety of arrhythmias. Aconitine, itself, is widely employed experimentally for testing new antiarrhythmic agents. The selection of an agent must, of course, depend upon the electrocardiographic evaluation of both the rhythm and conduction disturbances occurring. Concurrent respiratory support may be required.

Oleander

The Oleander **(Nerium oleander)** is so widely cultivated in Florida around homes and public buildings and along roadways that it might be considered a runner-up to the orange blossom as a state flower. It and other members of this group which include the Yellow Oleander **(Thevetia peruviana)**, Lilly-of-the-Valley **(Convallaria majalis)**, and Foxglove **(Digitalis purpurea)** all have various digitalis-like glycosides as their toxic principles.

Two features are of particular note. After chewing or ingesting parts of these plants or drinking the water from a vase in which the blossoms had been placed, there is a local irritation noted to the mucous membranes of the mouth and stomach followed by abdominal pain, emesis, and diarrhea. Unlike pure cardiac glycosides, the crude plant material contains high concentrations of saponins and other irritants. The immediate anorexia, nausea, and emesis is due to these rather than to the digitalis glycosides.

Since most intoxications will be seen in norkalemic children with normal hearts, one most frequently will encounter conduction defects rather than increased automaticity as may be seen during digitalis therapy. The need to institute therapy must be based on an analysis of the electrocardiogram.

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Allergic Responses to Sensitivity Produced by Plants*

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Abstract: A general overview of plant allergy is presented with specific discussions of allergic and irritative conditions of the skin, respiratory system, and gastrointestinal tract. Specific etiologic factors and treatment are discussed.

The response to foreign materials by the human host is a function of the "immune system." This system is a normal constituent of the "survival kit" inherent to every living body. Its function is the detection, recognition, and elimination from the body of substances recognized as foreign. Usually, this function is efficient and successful without detriment to the host. Occasionally, when the foreign substance is extremely antigenic, or when the activity of the immune response is inappropriate, harmful sequelae may be produced that may cause tissue damage. The response to foreign substances also depends on the genetic constitution of the host.

A plant, to mediate allergy, must be a sensitizing plant. It must have, in its composition, certain chemical configurations which are capable of producing allergic reactions in the human host. This sensitizing material must come in contact with a host who has the capability of recognizing this foreign substance and then producing a neutralizing material. This neutralizing substance is called an antibody and combines with the antigen to form an antigen-antibody complex which in most cases can readily be eliminated. This is usually done with no injury to the patient. Contact may be with any portion of the plant that contains the antigenic material or with anything that can carry the antigen from the plant to the host. Direct contact is contact from plant to host, indirect contact is contact of the antigen via air, water, or anything that carries the antigen from plant to host. In the air, these volatile particles carrying antigen are called osmyls. Certain plants, such as algae, release the antigenic material into water. Animals can carry antigen in their fur, but regardless of how the antigen contacts the sensitive individual, there must be contact between antigen and host to produce an allergic reaction. The first contact seldom produces an allergic reaction. It takes time for the sensitizing material to sensitize the host.

The primary response of the body to a foreign material is phagocytosis and inflammation. If the foreign configuration is eliminated at this encounter, the host's response terminates. This is a nonspecific response. If this response fails to eliminate the offending agent, the body begins to react specifically. It first processes the foreign material which is then known as antigen and the second response is stimulated. This second response is termed a specific response and in it the antibody is formed. The specific immune response may occur in two forms, first the elaboration of humeral antibodies known as immunoglobulins and named IgE, IgG, IgM, IgA, and IgD, and a second response, that of a lymphocytic or a cell-mediated antibody. The first is a humeral response and the second is a cellular response. These responses may act independently or together in the same patient during the same insult. In addition to these mechanisms is the capability of the immune system to enhance the immunologic reactions through the action of complement and a bank of memory cells that recollect and recognize the antigen, if it is reencountered. If the antigen is fully and successfully eliminated at this stage, the immune response terminates. Normally, the antigens are successfully eliminated at this point without undue harm to the host. If the antigen persists, the tertiary responses are called into play. The antigen persistence may result from the nature of the antigen or from genetic defects. If antigen persists, the four types of immunologic responses can be elicited, and immunologically mediated disease may occur. If the antigen is eliminated early in this phase, the response is terminated with more or less minimal discomfort to the patient. If the response is ineffective and the antigen persists, more harmful sequelae of the immune response emerge as "autoimmune disease" during which the

* Photographs 55 through 58.

host sustains injury that may or may not lead to death.

Sensitivity reactions to plants may affect the human body in many ways. They can affect practically all organs and systems, especially the gastrointestinal tract, skin, and respiratory tract. The clinical symptoms of the GI tract are manifested by diarrhea, anorexia, nausea, vomiting, general malaise, and possibly fever and toxemia. They can also be manifested by inflammation of the lips (cheilitis), circumoral dermatitis (especially from oranges, carrots, and spinach), allergic stomatitis, canker sores in the mouth (aphthous ulcers or stomatitis), and possibly geographic tongue. These symptoms follow the ingestion or the contact of certain roots, leaves, or berries of plants not regarded as foods. These symptoms may be produced by mechanisms other than allergy. Thus, so-called poisonous plants growing in the yards and in the fields may cause GI symptoms by such mechanisms as irritation or toxic reactions usually relegated to poisons.

In the respiratory tract, the majority of insults occur by inhalation. Plant particles, plant chemicals, plant osmyls, pollens and other plant airborne substances of various types may act as antigens or carry antigens. In addition to the inhalants, symptoms of the respiratory tract may be triggered by ingested and injected material. The major forms of respiratory reactions include rhinitis, conjunctivitis, and asthma. Of the plant antigens, pollens are the most common. Following immune reactions from pollens, there is release of vasoactive amines which cause vasodilatation of the capillaries, hypersecretion of the mucous membranes, and edema. Due to continuity of the mucous membrane, all the components of the respiratory tract including the paranasal sinuses, nasopharynx and the lungs are affected. The lung responds with bronchospasm, edema, and secretions of the bronchial tree, which may lead to ventilatory insufficiency and obstruction and wheezing. Hayfever or allergic rhinitis is caused by edema of the nasal mucosa causing difficulty of breathing through the nose, rhinorrhea of a watery mucous, and sneezing. The pollen of plants is a very frequent cause of allergic rhinitis. These pollens are characterized by being airborne and reach the noses of susceptible people. These symptoms tend to be seasonal for each type of pollen reflecting the pollenation dates. However, not all pollens are antigenic. Of those pollens that are antigenic, to produce symptoms, the pollen must be airborne in sufficient quantity to cause symptoms, the pollen must contain specific antigen to cause trouble, and the plant must be widely and abundantly distributed. The pollen seasons in Florida last from February until cool weather. Many patients are allergic to molds, others are allergic to the emanations of insects. Pollens and other inhalants may be part of the cause of sensitivity to dust (Table I).

In summary, the grasses pollenate in the spring, usually lasting from February to May, except for Bermuda and Bahia grasses which pollenate until August and November. The weeds pollenate in the spring and midsummer or even later. The trees pollenate early except for Palm and Melaleuca which pollenate through September. Not all pollens are antigenic, some do not produce symptoms because they are too heavy to be airborne and are carried by insects. However, certain people who play or work among plants with heavy pollen can become victims to respiratory allergy by being close enough to the pollen to get their noses in an atmosphere of a larger quantity of antigen. Smelling flowers, that never cause nasal symptoms normally, may become a sneezy business.

Another response by the respiratory tract is allergic alveolitis. This entity is seen mainly in nonatopic patients. It is produced by the inhalation of various industrial and agricultural antigens such as fungi in moldy hay and other grain dusts containing molds. The effect of these agents is to stimulate IgG precipitating antibody in the serum which forms complexes with the antigen in lung-mediating injury in a type III fashion. The primary effect of the antigen-antibody complexes is to induce a local Arthus reaction in the lungs with primary involvement of the bronchioles and alveoli resulting in bronchiolitis and alveolitis. The condition is characterized clinically by cough, dyspnea, and cyanosis. Wheezing is usually absent, but systemic findings of chills, fever, and loss of weight are common. Radiographic changes include micronodular infiltrations followed by diffuse fibrosis and honey-combing affecting mainly the upper lobes.

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Table I. — Plants Causing Respiratory Symptoms

	Pollenation dates (approx.)
Grasses	
Bermuda Grass	February-November
Johnson Grass	March-July
Timothy and Redtop	March-April
June, Perennial Rye, Orchard, Meadow Fescue	February-March
Bahia	May-August
Sudan	April-May
Weeds	
Lamb's Quarter	January-April
Red Sorrel	February-May
Plaintain	March-May
Baccharis	October-December
Mexican Tea and Pigweed	July-August
Trees and Shrubs	
Palm	May-September
Melaleuca	April-September
Australian Pine and Mango	January-March
Oaks	February-April
Elm, Maple, Willow	January-February
Cypress, Sweet Gum, Sycamore	February-May
Eucalyptus, Box Elder and Bayberry	February-May
Mayberry and Privet	February-March
Orange	January-April

Clinical manifestations of allergy of the skin due to plants are mainly of two types: urticaria and atopic type reactions of type I variety and contact type dermatitis due to the delayed type IV reaction. Other types of plant dermatitis are due to mechanisms such as poisons, irritative dermatitis due to nonallergic mechanisms, and mechanical injury due to thorns and such means. By far the most recognized reactions produced by plants are those occurring in the skin. They can be classified into two main groups: allergic contact dermatitis and irritative contact dermatitis. Allergic contact dermatitis is also called dermatitis venenata or allergic eczematous dermatitis and is produced by the exposure of sensitized individuals to contact allergens. It is a delayed hypersensitivity reaction. The clinical picture of its acute phase is characterized by redness, edema, vesiculation, weeping, crusting, and is usually accompanied by marked itching. If the condition becomes chronic, the involved skin becomes thickened, fissured and may become pigmented. Certain contactants may produce a dermal contact dermatitis in which the eczematous component is minimal or absent and may resemble urticaria or angioedema. The clinical picture of allergic contact dermatitis may be closely simulated by the various eczematous dermatoses such as irritant contact dermatosis, atopic dermatitis, nummular dermatitis, seborrheic dermatitis, and certain eruptions due to fungi and bacteria.

The location, clinical course, and appearance of the eruption, together with history of exposure, and proper evaluation of patch tests help differentiate these conditions. Factors influencing allergic dermatitis are: frequency, duration, and intensity of the exposure to the antigen. The degree of allergic sensitivity is altered by the presence of infected, inflamed, or traumatized skin and the area exposed to the contactant. Some areas of the skin are more sensitive than others. The eyelids are more sensitive while the scalp is particularly resistant to contact dermatitis. Dermatitis may appear in areas distant from the site of contact if the host has previously been contacted at a different place. Pressure and friction increase the contact; perspiration can dissolve certain chemicals releasing them for the production of allergic dermatitis. Conversion of

the skin to alkalinity from a normal acid pH seems to enhance allergic contact dermatitis. Certain diseases appear to decrease reactivity of the skin such as cancer, lymphoma, and other diseases. Genetic factors in this disease may become intractable on repeated recurrences during this time in the patient's life.

Poison ivy (Rhus) contact dermatitis is probably the most common of the plant allergic contact dermatitides in Florida and in the United States. It is caused by a plant oil which is an oleoresin of whose components urushiol contains the catechols which are the sensitizing chemicals. The Rhus plants are poison ivy, poison oak, and poison sumac, among others. The antigens of these plants are essentially the same. These antigens are closely related to the antigens found in Japanese lacquer, cashew nut trees, mango and the marking nut tree of India. The eruption produced is an allergic contact dermatitis usually characterized by redness, papules, vesicles, and bullae often in linear streaking. Occasionally, urticaria and lesions resembling erythema multiforme, measles, or scarlatina occur from svstemic absorption of the poison ivy antigen. The dermatitis is produced by exposure to a portion of the plant that has been bruised. An uninjured plant seldom causes trouble allergically. Smoke from a burning poison ivy plant causes no trouble unless there is particulate matter containing the oleoresin, however, most visible smoke is visible because of the particulate material. Involvement of the mucous membranes of the mouth and the rectum due to the chewing of the plant leaves or to oral sensitization is not uncommon. The dermatitis can be acquired from oleoresin contaminated animals, clothing. tools, and adult or children's toys. Fomites contaminated with oleoresin in a dry state remain antigenic for a long time. Washing with soap and water or detergents render the contaminated material noneffective. The best prophylactic practices to prevent the appearance of the dermatitis after exposure are: know the plants and avoid the handling of them; realization of possible contaminants in clothes, fur and so forth, and the use of soap and water, and detergent washings. There is no topical measure to prevent poison ivv dermatitis. The treatment of mild dermatitis varies with the mildness of the rash and begins with mild shake lotions such as calamine to which phenol and menthol may be added. Antipuritic measures such as Valisone or similar sprays may be used. Steroids may be used but should be used judiciously. Specific prophylactic measures are difficult to attain. Results tend to be mediocre unless continued for a very long time. Prophylaxis may be attempted in cases where there is a marked necessity because of extreme sensitivity and severity, or for people whose jobs require more than average contact with plants. Hyposensitization can be accomplished over a long period of time, but there does seem to be a time limit to the duration of hyposensitization after the end of the prophylaxis in many cases.

Pollens are not only inhalant antigens producing allergic respiratory symptoms but also produce antigens that produce allergic contact dermatitis. There are two distinct antigens — a protein fraction mediating asthma and allergic rhinitis, and an oleoresin antigen producing allergic contact dermatitis. This type of dermatitis occurs mainly in outdoor or field workers such as farmers, gardeners, carpenters, foresters, and others. The principal sites of pollen dermatitis are exposed surfaces of the skin. This characteristic is also found in photosensitivity and the lesions of both may be mistaken for each other. The pollen dermatitis tends to be less acute because there tends to be less pollen and therefore less oleoresin adherent to the skin. Ragweed oil dermatitis can be mediated not only by ragweed pollen but also by the leaves and stems of the plant. In early uncomplicated cases, the face, eyelids and sides of the neck are involved. The dermatitis is sharply marginated by clothing. In chronic cases the lesions may become generalized. A patient sensitive to ragweed oil may have associated sensitivity to pyrethrum, chrysanthemum, and turpentine.

Other plants causing plant oil dermatitis are:

Chrysanthemum, Aster and Daisy: All belong to the same botanical family. Dermatitis appears in the late fall and early winter. Most cases involve the eyelids and face but wide involvement is not usual. Arnica and aster may cross react.

Philodendron: Is used as interior and patio decoration. Allergic contact dermatitis is common from several species especially **Philodendron Cordatum**. Diffenbachia is closely related in allergenicity.

Caster Bean: May cause dermatitis and may be poisonous if ingested.

Lillies: May cause dermatitis to those engaged in their commercialization.

Tulips: Some of these bulbs may cause a painful, dry, fissured, and hyperkeratotic eczema under the free margin of the nail and extending to the fingertips and the periungal region. The aller-

gen is a lactone.

Narcissus and Hyacinths: Dermatitis of these plants may be of the allergic type, but more often is an irritant reaction to bundles of calcium oxalate in the outer layers of the bulbs. These crystals penetrate the skin and cause a dermatitis resembling a fiberglass dermatitis.

Miscellaneous flowers and plants that cause allergic contact dermatitis in humans at various times are dicondra, magnolia, daffodils, poinsettias, and century plants.

Plant Primary Irritant Dermatitis: Is frequently due to contact with fluids or crystals in specialized hairs or other portions of the plant. The skin is injured by direct chemical or mechanical action. No allergic mechanism is involved and if the degree of exposure is sufficiently great, a reaction is provoked in every person exposed. Variation in susceptibility is due to anatomic factors, notably the thickness of the horny layer of the skin, to climatic factors which favor or impede the penetration of irritant substances and finally the strength of the chemicals. Primary irritant dermatitis is particularly common in children. Many plants contain chemicals that are strong irritants. The buttercup is an irritant plant. It contains an unsaturated lactone called protoanemonin formed by the breakdown of a glucoside in injured plants. Children chewing the leaves or stems of the injured plants may acquire blisters on the face and around the lips. Certain members of the daisy family also produce an irritant, bullous rash when crushed on the skin. Cactus-like plants, called spurges, may contain milky latex in their stems. This material has strong caustic properties. Gourds and cucumber plants contain juice that can irritate the skin. Plants of the mustard and radish family contain the glycoside singrin which is harmless in the dry state but is converted into an irritant, volatile oil of mustard in the presence of water. Pineapple juice contains bromelin, a proteolytic enzyme, that can cause a primary irritant dermatitis. The enzyme causes separation of the superficial layers of the skin and increases skin and capillary permeability. These effects resemble the mechanical damage produced by the needle-shaped calcium oxalate crystals in some of the plant bulbs. The tropical plant **Mucana Pruriens,** the source of itch powder, is a member of the bean family. It does not grow in Florida but can be bought in joke stores. Short, barbed spicules cover the seed pods of this bean. The active enzyme produced is named mucumain and is the principal ingredient causing itching. Allergic contact dermatitis and irritant dermatitis may be difficult to differentiate. Certain chemicals may be both irritant and sensitizer.

Plant irritant dermatitis may be due to mechanical irritation such as irritation from spines, thorns, specialized bristles, and hairs. Such mechanical irritation may be complicated by bacterial or fungal infection. Many grasses and cereals including barley, millet, and bamboo have sharp trichomes which may produce urticarial papules in workers handling crops or litter straw. Dogwood has T-shaped hairs which may produce urticaria when the leaf is rubbed in direction of the hairs. Certain tropical plants including palms and cacti have spicules which may cause dermatitis. The prickly pear cactus has barbs called glochidia that can enter the skin producing a dermatitis resembling scabies. Harvesting prickly pears produces an occupational hazard where these pears are picked. Covered parts of the body may be secondarily affected by the transfer of broken barbs from the primarily affected sites. Peeling ointments of salicylic acid may be used to bring about exfoliation of the skin with the imbedded barbs. Mechanical removal of the barbs is difficult.

An irritant form of marine contact dermatitis has been reported. During the summer months the primitive plant Myxophyceae, the blue-green algae, produces a greenish discoloration in lakes, ponds, and stagnant bodies of water. The skin irritant is probably a phyocyanin, a blue pigment specific for these algae.

Phytophotodermatitis is a plant solar dermatitis produced on a skin exposed to plant psoralens (furocoumarins) in the presence of sunlight. It has been observed that the photosensitization with residual pigmentation develops in skin that has come in contact with members of the Umbelliferae group such as figs, cow parsnips, wild carrot, fennel, anise, coriander, angelica, parsley, parsnip, and the gas plant. This has also been reported in individuals exposed to the oil of persian limes, in carrot processors, and celery pickers and handlers. The furocoumarin compounds are lipid-soluble and penetrate the skin easily. There are two requisites for the initiation of phytophotodermatitis: (1) contact with the sensitizing furocoumarin and, (2) subsequent exposure to ultraviolet irradiation of wavelengths greater than 3200 A (sunlight). High humidity increases percutaneous absorption of the furocoumarin and accentuates the action. Other clinical manifestations of phytophotodermatitis have been given special names such as Berloque's der-

matitis and Meadowgrass dermatitis. Berloque's dermatitis is produced at sites exposed to a combination of oil of bergamont (from citrus fruit) and sunlight. Oil of bergamont is probably the primary cause of the photodermatitis caused by perfumes. Meadowgrass dermatitis (dermatitis bullosa striata prantensis) is characterized by bizarre, criss-crossed linear streaks of erythema and vesicles or bullae which heal with hyperpigmentation. The photosensitizing agent is not a grass but a yellow-flowered wild parsnip which belongs to the carrot family (agrimony) or a common yellow flowered herb of the rose family. Any person sufficiently exposed to a plant containing furocoumarin is susceptible because a phototoxin and not a photoallergic mechanism is involved.

Phytodermatitis or plant dermatitis due to lichens, which are plants composed of fungi living in symbiosis with algae, have caused allergic contact dermatitis in foresters and others living or working in forests. The specific substance is apparently usnic acid which accumulates in lichenized fungi.

An eruption that appears to be due to plants may, in reality, be produced by other factors unrelated to plants. These eruptions may be produced by other causes such as arthropods, fungi, bacteria, chemicals and others. Such a dermatitis is called pseudophytodermatitis or a false plant dermatitis. Mites associated with grains and foods are quite common and may represent occupational hazards. The grain itch mite or **Pediculoides ventricosus** feeds on various insect larvae that infest wheat, barley, rye, and other grain straws and beans. The mite attacks man, especially when he is sleeping on straw mattresses. This produces a generalized eruption consisting of petechia, wheals and pustules.

The food mites or **Tyroglyphus farinae** may infest grain stores, mills and bakeries, and also food in the home. Contact with this mite produces a papular dermatitis. The cheese mites do not suck blood but their migration under the superficial scales of the epidermis produces an eruption difficult to distinguish from that of an allergic dermatitis. Cheese mites have been controlled by painting the cheese with paraffin and wiping or dipping cheese blocks in mineral oil, cottonseed oil, or glycerin. Bulb mites may invade the bulbs of plants stored either at home or commercially. The handlers of these bulbs can develop a pseudophytodermatitis. The sugar mites infest the workers in sugar plants, chocolate and candy plants and those who can and pack fruits and syrups. Dried fruits may be infested by the mite **Carpoglyphus passaurum.** Sorters, peelers, and packers of infested prunes may acquire a follicular, papular eruption.

Pseudophytodermatitis may be due to contact with poison hairs of caterpillars. In homes, caterpillars may crawl into clothing or bedding. Fomites infested with caterpillars may produce dermatitis even if the infested material is of long duration and in cold storage. Caterpillar dermatitis is an occupational disease of plantation workers. Dead larvae and cocoons of caterpillars as well as debris from infested pine forests can cause dermatitis which may occur throughout the year. The eruption is caused by microscopic hairs containing a toxin that produces lesions. An entire community may suffer from urticaria epidemica due to caterpillars. This type of dermatitis appears usually as an urticarial, papular eruption with vesiculation and even necrosis. Nodular conjunctivitis and severe damage to the eyeball can be a serious complication.

Various plant insecticides, including arsenical sprays and malathion, can produce contact dermatitis which may initially be diagnosed as plant dermatitis. Carnauba wax from a South American palm is used to wax oranges. This wax is also an ingredient of shoe, furniture, and automobile polishes, as well as cosmetic creams, lipsticks, and solid perfumes. Although this wax can produce contact dermatitis, it rarely does so.

Management of Contact Dermatitis Due to Plants

1. Adequate diagnosis.
2. Wash lesions with soap or detergent and water to get rid of as much of the irritant or allergenic matter as possible.
3. Local dermatological therapy as for acute derm-lesions with shake lotions with or without phenol or menthol.

The use of oral steroids is indicated for acute allergic contact dermatitis since the process is self-limited. A declining dose for several days will reduce the healing time in this condition without fear of complication from the steroid.

4. For chronic irritative contact dermatitis, allow healing with as little medication as possible. Watch for complications, especially infection and tissue damage. The use of antibiotics and possibly minor surgical debridement may be necessary.
5. For treatment of chronic allergic dermatitis it becomes necessary to identify the antigenic material by the various tests available. Until identification is made, symptomatic relief is given with antipruritics, antihistamines (as sedatives), and topical steriods if necessary and with care. There

is inherent danger of prescribing oral or parenteral steriods in these cases because of complications due to overdosing by patients who do not return.

Prophylaxis of allergic contact dermatitis is of little value. Local applications as screens are not effective in most cases. Hyposensitization is very time consuming, requiring long periods, and there is loss of immunity in a comparatively short time.

It is important to watch for and treat complications as they develop, if possible. These complications may be infection, bacterial or fungal, tissue damage, advanced immune responses, or mental reactions.

Treatment of acute respiratory and gastrointestinal allergic reactions consist of symptomatic therapy of the systems involved. Gastroenteritis of any cause requires constant care to prevent dehydration and electrolyte imbalance, especially in children. This is true in toxic, irritative and allergic disease of the gastrointestinal tract. Further treatment depends on the course after diagnostic procedures. The irritative cases usually clear more or less without dismay.

Treatment of the allergic respiratory cases depends on the antigenicity of the antigen in atopic patients and the immune reactions in the nonatopic patient. In atopic patients, the drugs of choice are the sympathicomimetic drugs, antihistaminic drugs, and steroids. Many other drugs are used according to the training of the attending allergist. Avoidance of the offending factor is always a point, wherever possible.

Prognosis of allergic dermatitis:

Good, if condition remains reversible.

Poor, if condition becomes irreversible due to marked tissue damage and scarring.

Recurrent, if antigen is not removed or neutralized.

Suggestions for Avoiding Problems Caused by Contact with Unknown Plants

Try to become familiar with various plants in your area, especially those in your yard and surrounding area. Descriptions of plants may be obtained from the local Department of Agriculture extension office or from libraries.

Do not eat any wild plants including, of course, mushrooms and toadstools until positive identification has been made.

Keep plants, especially seed fruits and bulbs small enough to be eaten, away from small children and teach older children to keep unknown plants and plant parts out of their mouths.

Make sure your children recognize poison ivy and similar plants native to your region and instruct them to avoid contacting them with their skin or clothing.

When burning weeds or plants, do not inhale the smoke since some poisons can be carried in this manner.

Bulbs and seeds used for home gardens should be stored in plainly marked containers out of the reach of children and their pets.

Summary

Dangerous plants are of all types, including the smallest algae in ponds to large trees. They are all of different ability to cause harm to people, and people are of various susceptibility to the harm. In some plants, the harm comes from the stems and leaves; in others, from the roots and fruit. There is no sure way to tell which plant will always produce harm nor is there a sure way to know which person will be harmed. Recognition of plants requires training and experience but more importantly a definite interest and desire to protect the family, especially the children, from adverse reactions from plants. Allergic adverse reactions represents just one of the mechanisms by which adverse reactions are produced. A superficial explanation has been given to explain some of the reactions. It is a group of various reactions depending on many things: the plant-producing substances that can produce sensitization in people, people who are capable of being sensitized and react, plus all sorts of environmental, genetic and chemical factors that bring all these variables together. The mortality rate is not high nor is the morbidity but it could be and it could be one near and dear. Allergy can produce not only rashes of various sorts, but also a gamut of reactions found in allergic situations from hayfever to an itchy rectum.

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Mechanical and Miscellaneous Injuries

Sylvester A. Rose, M.S.

Abstract: Description is presented of plants with spines, burs, thorns and awns.

Florida has many native plants plus hundreds of plants introduced from other parts of the world. The majority fall under the tropical and subtropical category. A great number of the introduced plants are toxic; some cause internal poisoning, others external rashes. A number of native and introduced plants do not contain toxic constituents but are considered dangerous due to their spines, burs or thorns.* These sharp plant structures are capable of producing deep puncture wounds, scrapes or abrasions should a person or animal come in contact with them. Injury is subject to infection from fungi or foreign matter that may have accumulated on the plant structure. An example of this type injury is the "Citrus Eye Disease" discussed in a separate article. Each year 20 to 25 citrus workers are treated for this disease caused by the fungi species **Fusarium and Cephalosporium.** The worker's eye is stuck or brushed by a twig or branch of the tree causing infection that may result in blindness. Drugs for treatment of this infection are available at the University of Florida and University of Miami Medical Centers. The following plants contain spines or thorns on some parts of the plant.

Acacia spp.; Family: Leguminosae.

Acacias are small trees or shrubs. Most species produce yellow globular flowers. Foliage varies from large forms to feathery types. A number of acacias have stout spines along all their branches and trunks.

Agave Americana (Century plant); Family: Amaryllidaceae.

An ornamental plant with thick stiff leaves up to 6 feet long and 7-8 inches wide, gray in color. A tall flower spike is produced when plant is 10 years old. Plant dies after flowering. Tips of leaf have a stiff spine and leaf margins are also armed.

Aloe spp.; Family: Liliaceae.

A succulent low growing plant used as an ornamental. It produces bright red or yellow flower spikes. Leaves are grayish-green and contain stiff, spiny-toothed margins. Foliage used for burns and other skin ailments.

Amaranthus spinosus (spiny amaranth, pigweed); Family: Amaranthaceae.

A common weed in cultivated ground. Leaves are light green, flowers unattractive on a spike. Spines one fourth to one half inch in length are located in leaf axils.

Cacti spp.; Family: Cactaceae.

This family contains more than 1300 species. Plants are generally succulent with inconspicuous leaves. Forms vary in size and shape. Most cacti produce large attractive flowers and berry-like fruits that are edible. Spines cover most of plants surface.

Carissa spp. (Natal plum); Family: Apocynaceae.

Several carissas are used as ornamental plants ranging from prostrate forms to large shrubs. Plants produce white star-shaped flowers that develop into plum-like edible fruits. Leaves are dark green roundish and have a milky sap. Double spines are located at leaf nodes or joints.

Crataegus spp. (Hawthorn); Family: Rosaceae.

A shrub or small tree grown mostly in north Florida. Flowers are white, not very fragrant and produce small apple-like fruits. Spines, one inch or more in length, are present along branches.

Citrus spp.; Family: Rutaceae.

Most citrus is grown for its edible fruit. Trees vary in size for various types of fruit. Flowers are generally white but may have a pinkish tinge prior to opening. Leaves are glossy dark green and usually with a winged petiole. Spines, two inches or more in length, are common on water sprouts; new growth arising along branches of tree. Spines are also present on older growth and older trees—but length is usually less than one half inch.

* Photographs 43 through 54.

The Author

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Duranta repens (Golden dew drop); Family: Verbenaceae.

A large shrub or small tree with cascading branches and toothed leaves. Flowers are lilac in color and produced in drooping clusters. Fruits are golden berries which are considered poisonous. Branches contain numerous spines up to one inch in length.

Elaeagnus pungens (Silver-thorn); Family: Elaeagnaceae.

An ornamental shrub with light green foliage above and silvery beneath and dotted with small brown spots. New growth is rapid with cascading branches. Flowers are very small and occasionally produce fruit. Branches are armed with spines one inch or more in length.

Euphorbia splendens (Crown-of-Thorns); Family: Euphorbiaceae.

Low growing ornamental plant with colorful red or pink wax flowers. Stems of plants are completely covered with one Inch spines.

Palms spp.; Family: Palmaceae.

A number of palms have long spines along a portion of the leaf petiole. Included are Date palms which have a feathery leaf and Washington, Paurotis and Palmetto which have a fan-shaped leaf. Some spines are several inches in length.

Parkinsonia aculeata (Jerusalem thorn); Family: Leguminosae.

A small deciduous tree with feathery leaves. Flowers are yellow and produce pea-like seed pods. Green branches are armed with short, sharp spines.

Rosa spp. (Rose); Family: Rosaceae.

Roses are very common ornamental vines or shrubs. Flowers are single or double and come in many colors and bicolors and are generally very fragrant. Leaves consist of five leaflets and also some of three. Branches or canes contain few to many thorns.

Rubus spp. (Blackberry); Family: Rosaceae.

Blackberries are native vines found throughout Florida. Flowers are single, white and produce a black edible fruit. Spines are found on leaves and along entire cane or stem.

Severinia buxifolia (Box orange); Family: Rutaceae.

Severinia is a shrub used for screening purposes or hedges. Plant produces small white flowers followed by black, pea-size fruit. Green spines over one inch in length are produced along entire branches.

Smilax spp. (Bullbriar); Family: Liliaceae.

Bullbriar or saw-briar are native plants that contain large fleshy tubers beneath soil surface. Leaves are glossy and arrow shaped. Flowers are inconspicuous and fruit a small blackberry. Leaves and viny branches are covered with spines.

Solanum carolinense (Horse nettle); Family: Solanaceae.

A wild low-growing plant or weed with pale green leaves, white flowers and fruit a blackberry. Leaves and stem are covered with many white hairs that cause a painful burning feeling when touched or brushed against.

Yucca aloifolia (Spanish bayonet); Family: Liliaceae.

Spanish bayonets are stemless plants with all leaves arising from a central trunk. Leaves may attain a length of 2½ feet and a 3 inch width. Flowers are creamy white and are produced on tall spikes arising from center of plant. Tip of each leaf has a sharp, hard, black, stiff spine an inch or more in length.

Zanthoxylum (Prickly ash); Family: Rutaceae.

A native shrub or small tree with glossy, dark green, fragrant leaves. Small white flowers produce black seeds. Leaves and branches heavily armed with spines.

These are but a few of the many plants that contain spines or thorns, capable of causing serious injury. If thorny or spiny plants are to be included in one's landscape, be certain to place them in a location where they will not interfere with traffic. Some plants are more dangerous than others. Agave, Cacti, Palms, Euphorbia, Parkinsonia, Severinia, Smilax and Yucca have the most dangerous spines of plants listed. All are capable of causing severe puncture wounds and can cause blindness if they come in contact with the eye.

A number of pointed plant structures may cause punctures or other types of injury. The most common is a spine or thorn, an imperfectly developed leafless branch of a woody plant, which tapers to a fine point. Spines are often produced in leaf axils. Many spine producing branches become "spinose" or "spinescent" at the tip tapering off gradually into a rigid leafless point, showing every graduation between a spine and an ordinary branch. In some plants branches arise from axil or joint of a spine.

Spines may also develop at the apex or tip of a large leaf. Examples are yucca and Agave. In the case of Agave spines also arise along entire margins of leaf. Some spines are straight while others may be curved or hooked. The latter is common on leaves of several palms—Washingtonia, Paurotis Wrightii and native Palmetto. Spines may vary in shape, size, thickness, length and location on plant.

Another structure that may cause irritation if handled is the "bur." Burs occur on exterior portion of specific seeds such as Sweetgum and Sandburs.

Grasses, especially small grains, produce sharp structures labeled "Awn." These structures are found in seed head region or "glumes" of plant. Barley, rice, wheat and several other grains have this structure.

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Poisonous Mushrooms

Kenneth F. Lampe, Ph.D.

Abstract: Emergency treatment for child and adult mushroom poisoning history of poison cases, psychodelic use, effects of various types of mushrooms, and medical therapy are described.

Whereas in the past most ingestions of unidentified mushrooms have been associated with an occasional tasting by toddlers crawling about the back yard, changes in contemporary lifestyle can be expected to increase the frequency of mushroom intoxications in older age groups, the use of mushrooms to deliberately evoke a psychodelic response and the search for "natural foods." Mushroom intoxications, like any other, are dose dependent in severity, so the utilization of mushrooms as food, in particular, may be expected to more likely result in severe poisoning. Unfortunately Florida, as well as most of the remainder of the southeastern United States, does not have active mycological societies to provide public education on the hazards of eating unidentified species. The lack of previous experience with mushroom intoxications also hampers the physician in the diagnosis and institution of appropriate therapy. He is often misguided by the long propagated medical myth that atropine acts as a "universal antidote" in such intoxications.

A child brought to the emergency room who has been observed swallowing an unidentifiable mushroom within the past two hours and who is asymptomatic should have his stomach evacuated because of the potential for severe poisoning. As with any plant ingestion, the large fragments are most easily removed by inducing emesis. In a child this can be most readily accomplished by the administration of syrup of ipecac 1 to 2 teaspoons to a child under one year, ½ oz. to older children, with a glass of water and if the child is small, gently swinging him up and down in a position which will avoid aspiration (in a spanking position over the knee, for example.) Older children should be made to walk about. Emesis will generally occur within ten to 20 minutes. When vomiting has subsided, a slurry of approximately a half a cup of activated charcoal in ¾ cup of water should be administered. The child should then remain under close observation for the subsequent 24 hours by the parent who should be instructed to notify the physician or emergency room if the child exhibits later episodes of emesis or diarrhea. Mushroom ingestions in the small child differ significantly from those of the adult in that the mushrooms will have been eaten raw. Cooking tends to inactivate many of the simple gastroenteric irritants, which can, in a baby or toddler, produce emesis and diarrhea with refusal to take oral fluids resulting in an intolerable degree of dehydration and electrolyte imbalance. A number of fatalities in children following ingestion of "edible species" may be attributed to this.

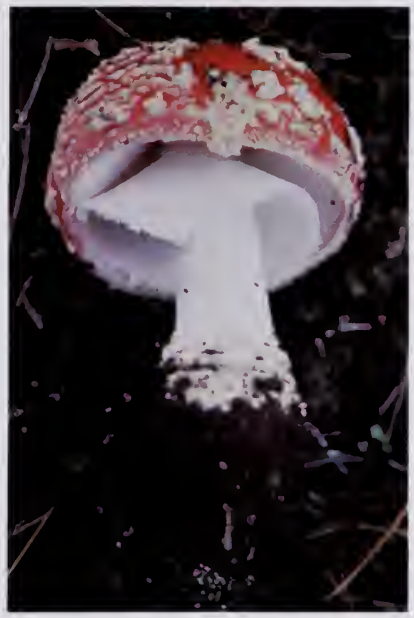
An individual entering the emergency room with symptoms of poisoning and a history of uncultivated mushroom ingestion during the preceding 24 hours must be examined with sufficient care to rule out other etiologies. I was called on an out-of-state consultation about a patient who had eaten a mushroom growing on the golf course. The man collapsed later in the morning but exhibited no signs characteristic for any type of mushroom intoxication. Nevertheless, the emergency room personnel, despite advice to the contrary, persisted in giving repeated doses of atropine until the man's heart rate was elevated above 180. A more careful workup then revealed that the patient's collapse was the result of an acute myocardial infarction.

Idiosyncracy to mushrooms reflected as abdominal pain, nausea, or diarrhea is apparently as common as to certain well-known trigger foods as chocolate or strawberries. When more than one individual is involved in an ingestion, if is useful to inquire if everyone who ate the mushrooms is sick and if anyone in the same family who did not eat the mushrooms is sick. Since mushroom broth provides as good a medium for bacteria as custard or mayonnaise, it should be determined if the mushrooms were reheated if served more than once and whether the mushrooms were eaten raw, sauteed, or boiled as in a stew. It is also necessary to determine if only those who drank alcohol with the mushroom meal or within 24 hours thereafter became ill.

In taking the history, the best index of seriousness of the intoxication and the future prognosis



Amanita Phalloides



Muscaria



Chlorophyllum Molybdites



Copinus Atramentarius



Inocybe Sp.



Gyromitra Esculenta



Psilocybe Sp.

of the patient can be made by establishing the time between ingestion of the mushrooms and the onset of symptoms. Symptoms occurring shortly after ingestion, up to six hours, of the mushroom or immediately after the ingestion of alcohol are indicative of an intoxication of low morbidity with excellent prognosis. Symptoms appearing after a latent period of many hours, often about 12 hours, are associated with serious intoxications and grave prognosis.

Regardless of the type of toxic mushroom, in nearly all cases the symptoms encountered initially will be nausea or abdominal cramps. The largest number of toxic mushroom species produce illness no greater than this and are thus classified as simple gastroenteric irritants. Of these, the one most commonly encountered in actual poisoning episodes in Florida is **Chlorophyllum molybodites (Lepiota morgenii),** named chlorophyllum not because it contains chlorophyll (no mushroom does) but because it makes a green spore print. Usually within about one hour of ingestion of this mushroom (cooked or raw), the patient will develop a severe gastroenteritis with both repeated vomiting and diarrhea. This may continue for as many as three days, requiring careful maintenance of fluid and electrolyte balance with intravenous fluids to prevent the development of hypovolemia. The treatment is otherwise symptomatic as for any severe gastritis.

Certain species of **Psilocybe, Panaeolus,** and **Copelandia** are found in Florida which contain significant quantities of the hallucinogen, psilocybin. Since these mushrooms require considerable quantities of nitrogen for optimal growth, they are often found in dung-laden cow pastures. If the stem of the mushroom is injured by the pressure of a fingernail, a dark blue stain appears after a few minutes. The psychological response is dependent upon the psilocybin content and the number of mushrooms ingested. Sometimes, 20 to 60 are ingested to obtain the desired response. Small dose levels primarily affect mood, generally producing a feeling of well-being, accompanied by dizziness and weakness; higher doses alter temporal and spatial perception and induce a variety of visual disturbances, sometimes including visual hallucinations. The effect usually commences within 30 minutes and begins to dissipate in between two to four hours. Psilocybin is stable both in dry and cooked mushrooms. Since the effects are so transient, no therapy is indicated in the adult other than reassurance as necessary. An occasional patient may show manic excitement which may be terminated by diazepam (Valium). It is necessary to empty the stomach by emesis or lavage. Significant intoxications in small children probably do not occur unless the mushrooms have been prepared in quantity to be served as food. The limited case reports indicate that children may respond with disorientation, hyperthermia, (102-106°F), and intermittent tonic-clonic convulsions; the latter effects, of course, require prompt medical intervention.

The illustration in children's books of a red capped mushroom with white polka dots is a stylized version of **Amanita muscaria.** Despite its species epithet, this mushroom rarely contains clinically significant concentrations of muscarine. The principal psychoactive component is muscimol, which is presumed to act on the aminobutyric acid (GABA) receptor in the central nervous system. Usually within 20-90 minutes after ingestion of sufficient quantity of this mushroom (or its close relative **Amanita pantherina),** there is a period of drowsiness or sleep. This is succeeded by elation, hyperactivity, illusions, or even manic excitement. The illusions differ in a qualitative sense from those produced by the psilocybin-containing mushrooms in that they are primarily misinterpretations of sensory stimuli rather than formed hallucinations. The periods of excitement may alternate with periods of somnolence. The intoxication is transient, rarely persisting more than six hours, and requires no pharmacologic intervention. Children who have ingested considerable quantities of these species cooked as a meal may become comatose, exhibit one or more tonic-clonic convulsions, and demonstrate a peculiar combination of neurologic effects somewhat resembling tetany. Drug control of the seizures may be required but the temptation to institute additional therapy during the brief intoxication should be avoided. Some patients may have a residual headache which persists for several days.

The parasympathetic stimulant muscarine is present in clinically significant quantities in certain species of **Inocybe, Clitocybe,** and **Omphalotus.** The onset of symptoms after eating these mushrooms is very rapid, usually within 15 minutes and rarely exceeding one hour. Which parasympathetic responses are evoked is dose dependent, however, every intoxication is characterized by profuse sweating which should be the basis of the differential diagnosis. Other signs which may be present are nausea, abdominal colic, blurred vision, salivation, rhinorrhea, and dizziness secondary to hypotension. Atropine is the specific and indicated therapy for this type of mushroom poisoning. A sufficient quan-

tity should be given to produce dryness of the mouth. The removal of undigested material from the stomach is recommended if spontaneous emesis has not occurred.

Corpinus atramentarius, the inky cap, is considered by gourmets to be a particularly delicious mushroom when cooked. In itself, it is nontoxic. However, it acts like the drug disulfiram (Antabuse) in that it will produce severe nausea, headache, and a sympathetic storm in patients who drink an alcoholic beverage within 24 to 72 hours after eating the mushroom. The active constituent is a cyclopropylglutamic acid named coprine, which, like disulfiram, inhibits the degradation of acetaldehyde, the initial metabolite of ethanol. This allows the level of acetaldehyde in the blood to attain a sufficient concentration to induce the adverse responses. No particular therapy is indicated. The patient should be reassured that he is not suffering from a poisonous mushroom and that the effects will subside in two to three hours. In particularly severe cases, propranolol (Inderal) may help to moderate the untoward reactions.

Of the mushrooms associated with a prolonged latent period between ingestion and the onset of symptoms, one has only been reported to produce serious poisoning in the United States on a few occasions. This is **Gyromitra esculenta** which differs from all the other mushrooms described in this article in that it does not have gills. Its toxin gyromitrin is hydrolyzed into monomethylthydrazine which acts as pyridoxine antagonist. Both gyromitrin and monomethylhydrazine are readily removed from the mushroom with boiling water in about ten minutes. Neither compound is present in significant quantities in the dried mushroom, which is one of the principal varieties of commerce, widely employed in restaurant cooking. However, sufficient monomethylhydrazine can be retained by the cooking liquid to produce an intoxication if it is eaten with the mushroom as a broth or stew. Symptoms usually occur six to eight hours after ingestion, usually with striking suddenness and severity. The initial symptoms are fatigue, dizziness, abdominal pain, and persistent emesis. In most poisonings, the patient recovers completely in two to six days. In more serious cases, a moderate to severe jaundice becomes evident in about 36 hours with the usual signs of an acute, fulminant hepatitis. The treatment is the same as for an overdose of isoniazid, that is large doses of pyridoxine (100 mg/day IV), replacement of fluids and electrolytes, ancillary therapy for convulsive seizures if these do not respond to the pyridoxine. If hepatitis develops, more commonly in the older patient, it is managed in the conventional fashion of high carbohydrate, low protein intake.

The most feared group of toxic mushrooms are those related to **Amanita phalloides** including **A. verna, A. virosa, A. bisporiger**a and certain species of **Galerina,** which are responsible for nearly all the fatal poisonings due to mushrooms. Poisoning is characterized by a prolonged latent period, usually 12 hours, between ingestion and the first signs of intoxication, which are nausea, vomiting, painful colic, and a severe, watery diarrhea. Despite the intensity of this phase, the patient usually improves quite rapidly over the following 24 hours and enters into a symptom-free period of up to three to five days. This is followed by an acute, often fatal hepatitis, occasionally associated with renal failure occurring late in the intoxication. If the patient survives the acute phase which lasts about ten days, recovery is rapid and complete.

There are a number of toxins in the **Amanita** species but the ones of clinical significance are a series of closely related, heat stable cyclic octapeptides named the amanitins. It has been estimated that one fresh mushroom, weighing about 50 gm (equivalent to 7 mg of amanitins), would be fatal for an adult. The primary target organ of these toxins is the liver. They act by inhibiting RNA polymerase which results in the rapid destruction of the hepatocyte, becoming detectable as early as one or two hours after ingestion of the toxin.

Delay in the institution of therapy for an **Amanita phalloides** type intoxication is associated with an incidence of fatality greater that 50%. In contrast, vigorous supportive care initiated early reduces mortality to less than 5%.

Since the first sign of poisoning is pronounced emesis and diarrhea, it is unnecessary to administer emetic or cathartics or to conduct a gastric lavage. Rehydration with glucose solution and correction of potassium loss and base deficit is indicated during the initial phase. If the patient can retain orally administered substances, the instillation of 100 gm activated charcoal will interrupt the enterohepatic cycling of the toxins. Infusion of 250 to 500 ml of 20% Mannitol will aid in the prevention of oliguria. Blood chemistry and prothrombin time determinations will be required to monitor the intoxication. The increase in serum transaminase level is the most sensitive indicator of hepatocellular damage. The SGPT increases at a faster rate than the SGOT. The values for LDH are also significantly increased with a marked elevation in LDH isoenzymes of frac-

tions IV and V. All clotting factors of hepatic origin fall simultaneously regardless of their individual biological half life. In all surviving cases, the rise in fibrinogen and Factor V is the first sign of recovery and is considered of prognostic value.

Treatment is entirely supportive and should not differ from that for acute viral hepatitis and fulminant hepatic coma. A number of controversial and experimental modes of therapy are currently employed in different poison control centers. These include dialysis, high dose steroids, thioctic acid, high doses of penicillin G, as well as a number of others. None of these regimens has, as yet, been documented by well conducted laboratory studies. The guiding principle for the successful management of this or any other type of mushroom intoxication is aggressive symptomatic care. Maintenance of fluids, electrolytes, and blood glucose is a more important element of treatment than any special drug or technique.

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Abrus Precatorius (Rosary Pea)
The Most Common Lethal Plant Poison

Joseph H. Davis, M.D.

Abstract: A study of the effect of the rosary pea—this is the most common of fatal plant poisonings. Diagnosis may be difficult without suspicion. Lack of initial clinical illness is no assurance of well-being after a few days. Action of abrin is similar to bacterial diseases such as cholera, diphtheria, and botulism. Three deaths are described. (This article is probably the most comprehensive in world literature, combining the pharmacological and pathological aspects of rosary pea poisoning. —Ed.)

Abrus precatorius was introduced into Dade County as an ornamental vine, quickly began to spread and now grows in profusion throughout South Florida. It is indigenous to most of the tropical and subtropical regions of the world. Common names abound and in Florida jequirity bean, rosary pea, or crab eye, are most common. The pods, which when dried upon the vines, split to reveal the uniformly sized 3 by 8 millimeter scarlet seeds with a small black spot at one end. In Florida this is the usual color although varieties elsewhere may have lighter coloration. The hard lustrous colored coat makes them attractive to adults for jewelry and to children for pea shooters and play. Fortunately the hard coat minimizes clinical poisonings because the exposure of these potentially lethal seeds to children is ubiquitious in Florida from Stuart southward. Despite this widespread risk we have encountered only two accidental and one suicidal death from plants in Dade County during the past two decades during which time we have investigated over 2,000 deaths from other poisons.

Report of Cases

Case 1. — This 2-year, 4-month-old black female died on November 12, 1961. Her terminal illness began about 2:00 p.m. on November 8 when she commenced to vomit. She was seen in the emergency room at 6:45 p.m. and was diagnosed as a case of gastroenteritis. At 9:00 a.m. on November 11 she was taken to a different emergency facility suffering from diarrhea and abdominal pain but no vomiting or fever. Again the diagnosis of gastroenteritis was made but parasitic infestation was included in the differential diagnosis. Later the same evening, at 10:20 p.m., she was taken back to the original emergency facility where her mother complained that the child seemed drowsy and had sustained an episode of "jerking" of the extremities. Again she was sent away only to return to the second emergency facility at 4:15 a.m. following an unequivocal seizure. (It would appear that "ping-pong" visits from one emergency room to another are less than satisfactory under any circumstance!) Her temperature was 100.8F. While being examined she expired at 6:01 a.m. The diagnosis was meningitis and the case was referred to the medical examiner for investigation. The total duration of illness was about three days 16 hours.

The most striking autopsy findings were confined to the gastrointestinal tract although there was moderate cerebral edema. The gastric mucosa, particularly the fun-



Fig. 1.—Gastrointestinal lesions observed in Case 1. (A duplicate of this photograph is published in Morton, J. F., Chapter 71 of Tedeschi, C. G., Tedeschi, L. G., and Eckert, W. G., Forensic Medicine: A Study in Trauma and Environmental Hazards, W. B. Saunders Co., 1977.)

dus, was a dark red purple hue with streaks of adherent grey mucous. The proximal small intestine was moderately edematous but pale. Most striking were the Peyer's patches of the ileum. These were edematous, red in color, and coated with a pale surface membrane. The cecum was very red and inflamed with the colon becoming less involved in the descending portion (Fig. 1). The entire gastrointestinal tract contained approximately 300 milliliters of hemorrhagic bile stained fluid of no characteristic odor. No seed fragments could be seen. No pathogenic bacilli were cultured. Hot ethanol extraction of intestinal content gave similar ultraviolet absorption curves as extracts of jequirity bean and negative absorption data with controls obtained from other autopsy cases.

Scene investigation revealed that the child had been holding a "red and black pea" on November 8. Abrus precatorius vines with seeds were noted In the backyard of the residence inside the City of Miami close to Jackson Memorial Hospital.

Case 2. — This 2-year, 4-month-old white male died on October 30, 1969. On October 27 diarrhea with bloody mucous commenced and continued through October 29. There was no vomiting, pain, or fever. At 5:00 a.m. on October 30 the child awoke, did not feel well but ate some toast, became weak and cool to the touch at 8:30 a.m. and was pronounced dead on arrival at a hosptial at 9:05 a.m. Clinical diagnostic confusion was engendered by an apparent epidemic of nonspecific enteritis within the family and among children attending a nearby church. The total duration of illness was about two and one half to three days. The case was referred to the medical examiner for investigatlon.

The most striking autopsy findings were confined to the gastrointestinal tract although there was a moderately prominent degree of cerebral edema. The stomach contained grey mucous and partially altered blood. Peyer's patches were erythematous and edematous. The colon had erythema and edema throughout. No pathogenic bacilli were cultured. An ultraviolet absorption curve on feces was similar to a reference curve from jequirity beans.

Scene investigation revealed Abrus precatorius vines in the backvard of the rural residence of the victim. It was learned that he had been playing with a can full of the seeds two to three days prior to the onset of illness.

Case 3. — This 25-year-old white male died on April 16, 1976. On the morning of April 11 he had placed 20 jequirity beans plus some graphite in a Waring blender and consumed some or most of the mixture. An hour or two later he sustained nausea and vomiting. Several hours later diarrhea ensued. He refused hospitalization. On April 13 the diarrhea and vomitus were bloody and, due to weakness, he could no longer resist transport to the hospital by his friends. He was admitted at 5:20 p.m. and then was transferred to another hosoital the same evening. He was noted to be suicidal, depressed, and confused. His blood pressure was 110/75, pulse was 110 and temperature was 99.2F. Hemoglobin was 15.2 gm% and hematocrit was 48.8%. His initial clinical appearance was deceptively unalarming to such an extent one clinician wrote "it is unlikely that any amount of the toxin was absorbed." The patient developed cardiac dysrhythmias and expired despite therapeutic efforts at correction. The total duration of illness was about four days. The case was referred to the medical examiner for investigation.

The most striking autopsy findings were within the gastrointestinal tract although there were a pronounced cerebral swelling, pleural and peritoneal effusions and aspiration pneumonitis. Both renal and hepatic tissues were swollen and congested. The gastrointestinal tract was extremely hemorrhagic including Waldeyer's ring, the posterior of the tongue, the pharynx, esophagus, stomach, and small intestine. The colon was least involved.

Scene investigation revealed no specific source for the Abrus precatorius on the premises but the rustic neighborhood had ample sites of growth.

Discussion

Toxic plants abound in Florida yet few deaths occur within the populations potentially at risk. Infrequency of cases compounds the difficulty of initial diagnosis for few physicians, veterinarians, health or police investigators have the experience to appreciate all the potential toxins. Accordingly those concerned should, at least, attempt to ascertain which few poisonings occur most frequently in specific target populations. The most likely suspect poison is that which experience teaches is most common.

Abrus precatorius has been responsible for all the fatal plant poisonings in Dade County and, to my knowledge, for all plant fatalities in Florida with the exception of one death in a child who consumed lantana. Abrus poisoning is uncommon but not exceedingly rare.[1] It should be considered when a child of pica age or disposition develops severe gastrointestinal symptoms with gross or microscopic blood in the stool. The common end stage of cerebral signs obviously would lead to diagnostic confusion with Reyes syndrome. Accordingly both of these conditions must be considered early in the diagnostic workup. The likelihood of Abrus poisoning is greatest during the fall of the year when the new crop of seeds are produced with soft not yet hardened seed coats. In the two accidental cases mentioned previously the deaths occurred on October 30 and November 12. On the other hand illness can occur at any season for seeds may have been cracked before ingestion or possibly a plant may have matured early or late.

Confirmation of the suspected diagnosis is to be found in the environment because access is tantamount to an explanation of the illness. Seeds or fragments in vomitus or stool are of great diagnostic value and no suspect stool or vomitus should be discarded until the diagnosis is confirmed. Symptoms may be delayed for several days after ingestion and indicates a need to prolong the retrospective environmental search.

Treatment of suspected poisoning is to induce vomiting, if the child is alert, and to purge with a saline cathartic. Additional therapy is mainly supportive with correction of fluid and electrolyte imbalance.[2] The seeds contain hemagglutinins which

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(His written works are well known, his teaching ability well appreciated, and his knowledge of Forensic Medicine is classic in legal circles. — Ed.)

may result in hemolysis[3] but this has not been the most prominent problem in our fatal cases. The clinical course may be expected to last for about 10 days with death intervening at any time. Due to the great toxicity, even one seed may be sufficient to kill an adult, there can be no temporizing with emergency care of the child suspected of ingestion even if it appears, at the time, to be clinically unaffected by the ingestion.

Although the literature on the toxicity, use and abuse of Abrus precatorius extends back for well over a century the real dangers of the plant have been minimized in some authoritative review texts. Kingsbury states "abrin . . . is not easily absorbed through the uninjured intestinal wall."[4] Watt and Breyer-Bradwijk state "if taken by mouth it does not with certainty produce toxic effects for the protein is likely to be digested."[5] Verdcourt and Trump state "as little as one seed having been reputed to cause death" and then gratuitously editorialize with "though this is doubtless an exaggerated claim."[6] Even more startling is the statement of Quisumbing that "it has little or no irritant action on the mouth and throat and is digested and rendered harmless in the stomach."[7] These errors are cited to caution the unwary physician because fatal poisonings by Abrus precatorius do occur in Florida and the poison, abrin, is extremely toxic in minute amounts the equivalent of one seed. Part of the confusion may result from species resistance, the dog being much less susceptible than man or horse.

Systemic poisonings may also occur by injection of seed content, a favorite tool used in the past by criminals in India. Local irritation effects are pronounced when seed content comes in contact with the eye and may result in necrotizing conjunctivitis.[8]

The seeds contain a number of substances, abric acid, n-methyltryptophan, glycyrrhizin, a lipolytic enzyme and hemagglutinins.[9] The most active and significant toxic component responsible for the clinical illness in the poisoned patient is abrin whose chemical structure and metabolic action has been recently clarified by the brilliant studies of Olsnes and his associates in Norway.[10] Abrin is one of a class of plant toxins which have analogous molecular structure or cellular reactions. These include ricin, from Ricinus communis. the castor oil plant, and probably cholera, botulinus and diphtheria toxins. Abrin and ricin are quite similar in chemical structure and molecular weight. Each consists of two peptide chains, designated A and B, connected by a disulfide bond. The B chain is the haptomer which binds to the cell membrane. The A chain, the effectomer, then penetrates the cell via endocytosis similar to the method found in many viral penetrations. The effectomer inactivates the 60S subunit of eukaryotic ribosomes thus inhibiting protein synthesis.[11]

Current interest in abrin stems from the search for the causes and treatment of malignancies. Stored abrin has been demonstrated to combine into a large molecule consisting of four abrin molecules. This large molecule is much less toxic than its abrin components but does exhibit a potent lymphocyte mitogenic activity.[12] So far no specific therapeutic applications have been demonstrated although empirical and injurious therapeutic uses have been attempted about the turn of the century particularly with inflammatory eye diseases.[8]

Summary

The most common fatal plant poisonings in Florida are associated with the ingestion of seeds of Abrus precatorius. Although the mature seeds have an extremely hard coat which resists digestion, there is no guarantee that this protection will be afforded the person who ingests the seeds. Therefore treatment must assure that all seeds have been expelled from the digestive tract. Lack of initial clinical illness is no assurance of well being for there may be a delay of several days following intestinal exposure to abrin, the toxic ingredient of the seed. Research in the chemistry and mechanisms of action of abrin reveal biochemical analogies to other plant toxins including those of bacterial origin such as cholera, diphtheria and botulinus toxins.

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Angel's Trumpet
Lethal and Psychogenic Aspects

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Abstract: Physicians are warned that intoxication by Angel's Trumpet (Datura Suaveolens) is becoming more frequent due to its use by adolescents and young adults as a legal, readily available hallucinogen. Ingestion of Angel's Trumpet flowers or a tea brewed from them results in an alkaloid-induced central nervous system anticholinergic syndrome characterized by fever, delirium, hallucinations, agitation, and persistent memory disturbances. Severe intoxication may cause flaccid paralysis, convulsions, and death. Treatment with intravenous physostigmine reverses the toxic effects of Angel's Trumpet. (Angel's Trumpet is but one of a number of plants, readily available in any community, which can have hallucinogenic effects frequently with serious side effects. — Ed.).

The death of two teenagers and hospitalization of many more led us to chemically analyze the alkaloid content of the beautiful subtropical plant known as Angel's Trumpet.* Angel's Trumpet, sometimes also called Devil's Trumpet, scientific name **Datura suaveolens,** is a tree-like shrub growing up to 15 feet high with large horn-shaped flowers measuring up to 12 inches long (fig. 1). This shrub is a popular ornamental plant in many areas of the southeastern United States, especially Florida.

Beginning in the spring of 1974, we received reports that many teenagers were known to be concocting a tea prepared from the blossom of the Angel's Trumpet, being careful to avoid the pistils as these were stated, among the flower-children, to be poisonous. The blossoms were cut into small pieces, chewed directly or swallowed with various fluids, including milk and carbonated drinks.

A favorite method was to concoct a tea by heating the particles of blossom in water. Another popular method was mixing the tea with an alcoholic beverage such as beer or wine. This is especially effective in producing the hallucinogenic effects.

Early in the summer of 1974, a group of these flower-children were hospitalized with gastrointestinal complaints. They displayed varying degrees of delirium and incoherence, obviously hallucinating. Two days later one of these young people was found dead in a pasture in which there was approximately a two inch depth of water. A few weeks later, a young teenager, while in a hallucinogenic state due to ingestion of a broth prepared from Angel's Trumpet, committed suicide by gunshot. The toxicologic analyses of the patients' blood in both these cases showed lethal levels of alkaloid identical to the material demonstrated in the flowers of Angel's Trumpet, which will be elaborated on subsequently.

A review of the pharmacology of the genus Datura indicates that the species of these plants contain several solanaceous alkaloids, principally atrophine and hyoscine (scopolamine). Historically, poisoning from the alkaloids of the Datura genus dates back throughout the history of the United States, with the first known episode being a mass poisoning of soldiers sent to Jamestown, Va., in 1676 to quell the Bacon Rebellion.[1] It is from this episode that the name "Jamestown weed" and the distorted name "Jimsonweed" are derived. These are the names of a wild form of the species common throughout the southeastern United States and known to be especially poisonous to animals. Datura plants and flowers have been used for psychogenic and poisonous properties since antiquity. This plant is apparently referred to by both Virgil and Shakespeare.

Symptoms from these plants vary not only with concentration of the drug but with a great variation in individual idiosyncrasy. Premonitory symptoms usually include thirst and visual disturbances, with progression into hyperirritability of the central nervous system, delirium, hallucinations, incoherence, elevations of temperature and tachycardia. At this point, subjects may become violent and attempt self-injury. Convulsions may appear. In many individuals, a comatose stage is reached almost immediately without progressing through the sequence of events, previously noted. Obviously the coma may progress to death, presumably by respiratory arrest.

* Photographs 28 and 29.



Fig. 1. — Angel's Trumpet, scale in centimeters. See illustration section.

Information received from some who have used these flowers for hallucinogenic purposes indicates that tea or broth prepared from three of the flowers may or may not produce the desired hallucinogenic effects, while a broth prepared from six plants almost always produces hallucinogenic experiences. When the tea or broth contains the extract of nine plants, more intense hallucinogenic experiences occur and at this point many experience a feeling which appears to be that of a paralytic condition, with many of the flower-children stating that when this much material was ingested they passed through the hallucinogenic phase and experienced a feeling of total paralysis with inability to move, but with full sensation present. The mystical significance of the number of flowers used by progression of threes is not known at this time.

Because of the obvious public health aspects of the problem, we have attempted to quantitate the content of alkaloid in the flowers of Angel's Trumpet as grown in our area.

Laboratory Analysis of Datura

The end 15 cm of three flowers (with pistils removed) was minced and soaked in a solution of 50% ethanol and water. The weak alcoholic solution was chosen because of the frequently stated observation that the materials prepared from the flowers achieved faster and more intense hallucinogenic effects when mixed with weak alcoholic beverages such as beer and wine.

The alcohol-water solution was transferred with several rinses to a separatory funnel and made strongly alkaline with addition of 0.5 ml of concentrated NaOH and 0.5 ml ammonium hydroxide. To this solution, by now approximately 50 ml, was added 200 ml of chloroform and the entire amount was shaken vigorously for three minutes. Aqueous phase was discarded and the chloroform, after addition of one drop of alcoholic HCl, was evaporated to dryness using a water bath and a stream of air. Then one drop of methanol was added and the entire sample was spotted on a thin layer chromatography (TLC) plate (precoated TLC plates, Silica Gel 60 F-254, E. Merck, Darmstadt, Germany). The TLC solvent used was that of Davidow et al: ethyl acetate 85 parts, methyl alcohol 10 parts, ammonium hydroxide 5 parts.[2]

The solvent front was allowed to migrate 14 cm from the point of application (right hand corner of Fig. 2, marked with an "X"). The plate was then removed and dried completely. Once dry the plate was rotated 90 degrees and the solvent was again allowed to migrate 14 cm. As a result of this two-dimensional procedure, a very good separation was achieved.[3]

After the plate had dried completely, it was then placed under an ultraviolet light at 254 and 350 nm and the visible spots were marked with a pencil.

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The marked spots were then carefully scraped off the plate, eluted in 3 cc of methyl alcohol, and scanned by using the UV recording spectrophotometer from 360 to 200 nm. Samples of measured quantities of pharmaceutical scopolamine and atropine were separately treated in the same manner.

Several flowers were treated in the same manner in an attempt to determine an accurate average amount of alkaloid. Based on curves obtained from the standards of purified scopolamine and atropine, it was determined that each flower contained approximately 0.20 mg of atropine and 0.65 mg of scopolamine. Thus, ingested broth prepared from three flowers could contain 0.6 mg of atropine and 1.95 mg of scopolamine. The extract of six flowers could contain 1.2 mg. of atropine and 3.9 mg of scopolamine. The broth of nine flowers could contain 1.8 mg of atropine and 5.8 mg of scopolamine. The recommended USP dose of scopolamine, oral or parenteral, is 0.5 mg. The average adult dose of atropine sulfate is also 0.5 mg. Thus, it would appear that the extract from six flowers, for example, would contain approximately eight times the usual therapeutic dose of scopolamine and three times the therapeutic dose of atropine.

References indicate that persons ingesting up to 500 mg of scopolamine have survived and up to 1,000 mg of atropine has allowed survival.[4] However, fatalities have occurred at very low levels (approximately 10 mg). This again points to the importance of individual idiosyncrasy.

In the TLC diagram (Fig. 2), spot 2 contains atropine and apparently a tryptamine; spot 5, scopolamine; and spot 8, another tryptamine. The other spots were not identified due to minimal UV absorption, unfamiliar UV absorption, and/or no reaction by iodoplatinate or ninhydrin spray.

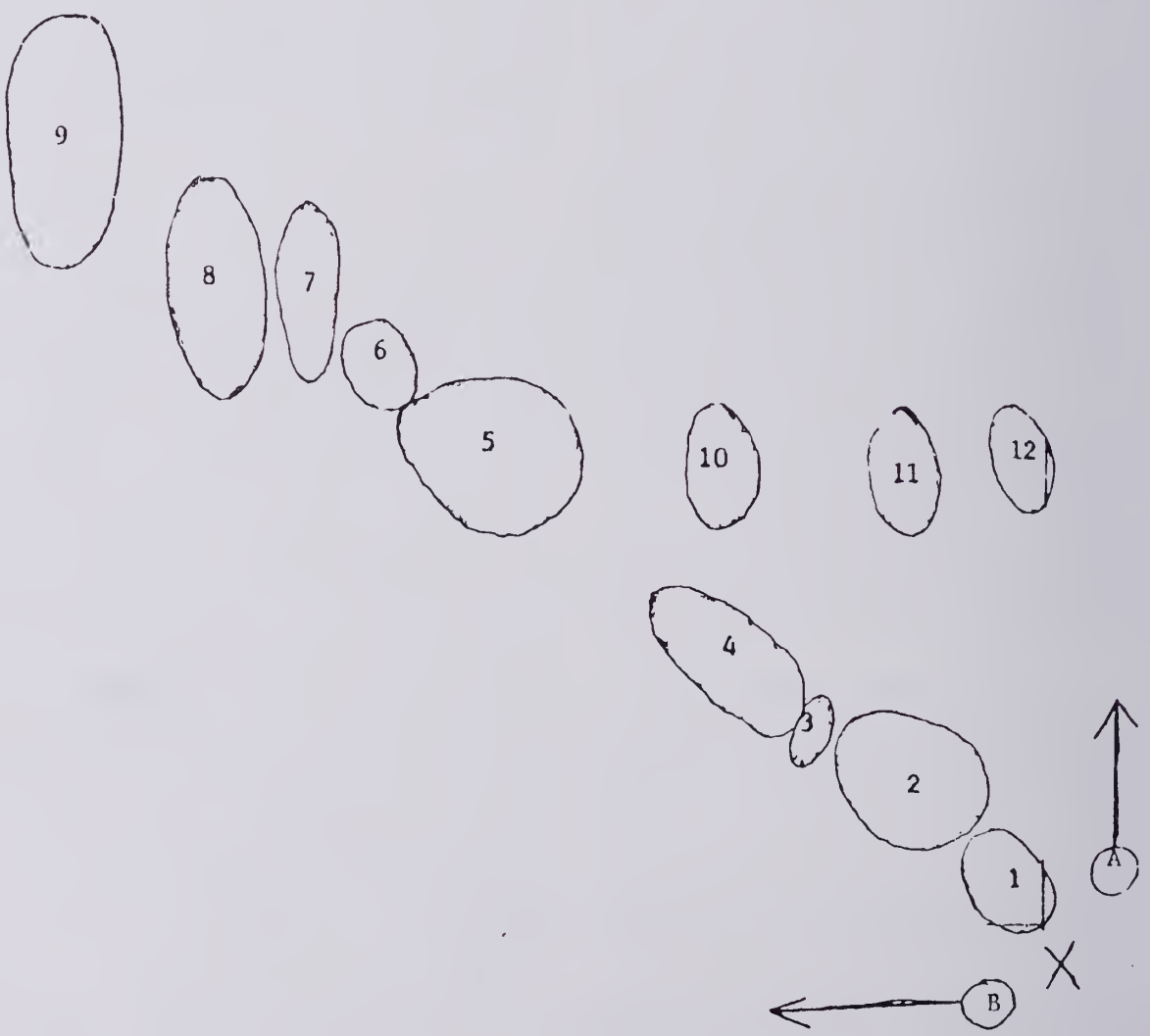


Fig. 2. — TLC of extract of Angel's Trumpet blossom, two dimensional separation (see text).

Because of the statements by the flower-children that the pistils were known to be poisonous, we attempted to analyze these also. We obtained good separation by the two-dimensional TLC procedure but were unable to identify the specific items in the separated spots. There appears to be one alkaloid component (but not scopolamine or atropine), and the specific type of alkaloid has not been identified as yet. The alkaloid content of the pistils would not appear to be near the concentration found in the blossoms proper.

Clinical Observations

Over an approximate six-month period, the physicians of the Mental Health Clinic, Brevard County, Florida, had an opportunity to observe ten cases of Angel's Trumpet intoxication and psychosis. The following case report is rather typical among these patients.

Case Report

Two 15-year-old boys were brought to a county hospital by police after they were found wandering naked and delirious through a field. One youngster was holding a flower that was later identified as Angel's Trumpet. Within five minutes of admission one patient developed profound muscular weakness and subsequently had a convulsion. He was treated with intravenous diazepam which suppressed the seizure. Physical examination revealed blood pressure 150/42, pulse 130, 26 respirations/minute, temperature 102.6F, dry and flushed skin, dry mouth, coated tongue, and widely dilated and fixed pupils. Babinski's signs were present. Deep tendon reflexes were 4+, and four-beat clonus and marked muscular weakness were noted. Weakness progressed to the point that the patient was unable to stand. No fasciculations were present. The patient was confused, disoriented as to time, place, and person, and experienced terrifying visual hallucinations.

The patient was treated with 2 mg intravenous physostigmine. By 30 minutes after treatment clonus had abated, deep tendon reflexes were 2 to 3+, and Babinski's signs were absent. Skin flushing had diminished markedly and the sensorium was beginning to clear. By 60 minutes after treatment the pulse rate was down to 100/minute. The patient was alert but continued to complain of intermittent visual hallucinations. His pupils remained widely dilated but did react minimally to light. Memory loss persisted.

The patient continued to have transient visual hallucinations for four days after treatment. His recent memory and the ability to imprint new short-term memories, as assessed by 3-item recall testing, were diminished for one week.

Thin-layer chromatography and ultraviolet scan of blood and urine revealed a mixture of alkaloids with scopolamine predominating.

Both subjects later reported having eaten Angel's Trumpet flowers before they became delirious. The patient's friend, who was less intoxicated, stated that the patient had eaten five or six flowers.

Observations

Table 1 represents the signs and symptoms we observed in ten cases. The majority of patients were initially obviously agitated and delirious. Visual hallucinations were prominent and seemed to prompt sudden behavioral changes. Patients changed rapidly from a quiet hallucinatory state to one of sudden violent excitement. The visual hallucinations were similar to those reported by users of LSD and included vivid colors, appearance of geometric forms, and visual misperceptions such as "buildings melting and pulsating." Devils, monsters, or bogeymen were reported by four subjects. It is noteworthy that visual hallucinations persisted for up to four days after intoxication.

The widened pulse pressure observed in seven of ten cases and marked muscular weakness observed in five cases were unexpected. Three subjects experienced sudden flaccid paralysis without involvement of respiratory muscles. They stated retrospectively that they had been aware of the paralysis and denied any associated loss of consciousness. The death of one subject may have resulted when he accidentally fell into a 3-inch deep puddle of water and drowned after paralysis occurred.

Symptom development in patients observed was rapid; five to ten minutes after the ingestion of teas, one to three hours after ingestion of plant leaves. The following course of symptom development appeared typical: intense thirst, visual disturbances, flushing, central nervous system hyperexcitability, sensory flooding, delirious incoherent state, hyperthermia, tachyacrdia, systolic hypertension, visual hallucinations, alternating levels of consciousness, clonus, and finally convulsions.

Table 1. — Symptoms Seen in Ten Cases of Angel's Trumpet Intoxication.

Symptoms	Number Cases
Deep tendon reflexes hyperactivity	10
Delirium	8
Dilated pupils	8
Disorientation	8
Dryness of skin and mucous membranes	8
Systolic blood pressure elevation	8
Flush	8
Hyperactivity or combativeness	7
Tachycardia	7
Visual hallucinations	7
Wide pulse pressure	7
Babinski's signs	6
Fever	6
Marked muscular weakness	5
Amnesia	4
Ataxia	4
Clonus	3
Expressive aphasia	3
Flaccid muscular paralysis	3
Grand mal seizures	3
Anxiety	2
Paranoid ideation	2
Urinary retention	1

The alternation between an obvious toxoid delirium and what appeared to be a drug-induced psychotic state with hallucinations and agitation was most impressive during the earlier stages of intoxication. As time passed, the symptom pattern became more similar to that observed in toxic delirium.

Discussion of Pharmacology of Angel's Trumpet Alkaloids

Angel's Trumpet contains several alkaloids of the tropane configuration principally atropine, hyoscyamine, and hyoscine (scopolamine). Their major effects are to inhibit the action of acetylcholine on structures innervated by postganglionic cholinergic nerves. High doses of these antimuscarinic agents can block neurotransmission at autonomic ganglia and at the myoneural junction. This curariform action of high concentrations of hyoscine may well explain the muscular weakness and flaccid paralysis seen in some subjects intoxicated by Angel's Trumpet.

Hyoscine (scopolamine), the major alkaloid found in Angel's Trumpet, is the most toxic of these alkaloids. Idiosyncratic responses occur more frequently with hyoscine than with atropine, and only 1% of an oral dose of scopolamine is eliminated in the urine over a 24-hour period, thus predisposing the patient to cumulative toxicity. In high doses hyoscine may inhibit central response to histamine, 5-hydroxytryptamine, and norepinephrine.[5] This may represent one pathway of the psychotomimetic mechanism. The disruption of acetylcholine as a central neurotransmitter by the large doses of scopolamine ingested by these patients may represent another central psychotomimetic pathway. Depression of the inhibitory portion of the reticular activating system, particularly by scopolamine, may explain the flooding of the sensorium and agitated delirium. Ostfeld and Arguete[6] have shown that atropine reduces the voltage and frequency of the alpha rhythm and consistently shifts EEG rhythm to slow activity. Scopolamine antagonizes EEG activation by hypothalamic reticular formation stimulation.[7] The diminished cortical arousal potential coupled with relatively greater loss of midbrain reticular inhibition may be the mechanism that liberates diffuse visual hallucinations and agitated delirium.

The wide pulse pressure observed may be explained in terms of the work of Cullumbine and associates,[8] who showed that even a 2 mg dose of atropine raises systolic and lowers diastolic pressures, thus increasing the pulse pressure.

The dilation of cutaneous blood vessels by atropine and scopolamine produces the dry atropine flush we observed in these patients. Fever results from both a central hyperthermic response and inhibition of sweating. Large doses of scopolamine also increase basal metabolic rate and thus further elevate core temperature.

Treatment of Angel's Trumpet Intoxication

Treatment of the central nervous system anticholinergic syndrome induced by Angel's Trumpet intoxication should begin immediately upon its recognition, with gastric lavage followed by intravenous injection of 1 to 4 mg physostigmine. The physician should be aware that repeated doses may be necessary for severely intoxicated patients due to the rapid destruction of the drug.[9] Phenothiazines should not be given because they potentiate the anticholinergic effects of the alkaloids and by their alpha blocking effects may precipitate cardiovascular collapse and death.[10]

Summary

We have presented data from the investigation of a series of deaths and clinical illnesses due to intoxication from the ingestion of Angel's Trumpet in varying vehicles, as described. A brief history of the genus Datura is given, and a report on our laboratory analysis of the quantity of certain alkaloids in the flower, Angel's Trumpet. Clinical observations with a typical case report of nonlethal cases have been presented, as well as a discussion of the pharmacology and treatment of Angel's Trumpet intoxication.

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Data From Bureau of Vital Statistics
With editorial Comment

L. E. McHenry, M.D.

Information from the Bureau of Vital Statistics, State of Florida, indicates that from the years 1973 through 1976 there were 39 deaths in Florida primarily due to insecticide poisoning. The categorization of these deaths is indicated in Table 1.

Table 1. — Insecticide as Primary Cause of Death.

	Accident	Suicide	Homicide
1973	1	7	
1974	3	6	
1975	1	5	
1976	4	11	1

This type of death and poisoning is covered comprehensively in another article in this issue and need not be covered further in this section. During the same time period, a total of five deaths were reported in three years due primarily to ingestion of poisonous or toxic plants as the primary cause of death. These deaths are categorized in Table 2.

Table 2. — Poisonous or Toxic Plant as Primary Cause of Death.

	Accident	Sulcide
1974	1	1
1975		1
1976	1	1

One of these five deaths resulted from a poisonous plant which was ingested in another state (California Western Hemlock), and the other four deaths were reported from only two counties, Dade and Brevard.

Are these valid statistics? I suspect not! Is it possible that poisonous or toxic plants were major contributing factors to deaths in only two Florida counties? Perhaps a closer look at these deaths might provide some insight in this regard. One of the deaths, a suicide, was due to the intentional ingestion of Rosary Pea, also dealt with in another article in this issue.

Two of the suicides (both teenagers) were due to gunshot wounds as the specific lethal agent. However, in each of these two cases, the deceased was in an hallucinogenic crisis, one due to the intentional ingestion of psilocybin — containing mushrooms, the other due to the intentional ingestion of Angel's Trumpet, also an hallucinogenic plant. Both of these topics are covered elsewhere in this issue. In each of these cases, while no one can argue the fact that the gunshot wound was the lethal episode, one must consider that the hallucinogenic agents which these people had ingested must be considered the basic cause of the suicidal act. Another death resulted when a college student jumped from the seventh floor of the dormitory while under hallucinogenic influence of psilocybin mushrooms.

One can speculate as to whether there may be other gunshot wounds or other violent deaths reported in which the basic agent leading to such an event is either not detected, not considered, or if so, is not properly entered on the death certificate to provide useful information to the Bureau of Vital Statistics. Such information is critical in the proper evaluation of all forms of violent death.

For such reasons as these, a toxicologic analysis should be performed on the blood or other body fluids of any deceased person who dies a violent death. When positive findings are found in these analyses, such information should be noted in the proper area of the death certificate. In my opinion, it is negligence not to do so.

These same remarks are appropriate in relation to any drug abuse, including therapeutic agents, which may actually be the triggering mechanism leading to a violent death, whether accidental, suicidal, or homicidal. Only by including such pertinent data for purposes of statistical analysis can we arrive at information indicating the real danger of poisonous plants, other poisonous agents, drugs of abuse, and therapeutic drugs, etc. Only by such data accumulation can we arrive at conclusions

for the public benefit. A typical example which has been of such benefit is the evolution of the drug Darvon. At one time an over-the-counter drug, and viewed with little concern by the medical profession, an increasing number of overdoses and deaths have finally resulted in adding this drug to the controlled drug category, as it should be. Only by such statistical analysis of valid death certificate data will potentially dangerous plants come to the attention of the Federal and State Health programs and the medical profession. This is not to minimize the importance of case reports, such as the articles elsewhere in this issue. However, only by analysis of the total statistical picture can the relative importance of such poisonous agents be assessed.

Finally, as I stated earlier, I suspect that a number of the death certificates supplied to the Bureau of Vital Statistics are devoid of basic important information, either due to ignorance of this information, inadequate investigation of death, or because of negligence in not reporting known basic information in these cases. The loss of this basic data, regardless of reason, is a major loss from the viewpoint of the public welfare.

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Pediatric Facets of Poisonous Plants

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One of the most perplexing situations in medicine is the patient who has ingested or been exposed to plant materials. The patient most frequently encountered is a child under five years of age. The parent may not know the name of the plant or from where it came or if it is toxic. Frequently the child cannot or will not give details about an ingestion. What plant, which part, how much and when are important factors. The physician may be consulted by the telephone or he may see the patient in his office or in the emergency room where plant information is usually very limited. There are so many native, cultivated and imported plants in Florida that identification can be a major problem. The colloquial terms and lack of botanical knowledge on the part of the caller and the physician add to the vexing problems. For instance, the rosary pea **(Abrus precatorius)** may be known as jequirity pea, precatory bean, crabeye, prayer bead, love bean, lucky bean as well as Spanish terms in south Florida. Once identification is completed, information on toxicity may be inadequate and misleading and management controversial.

Fortunately, serious and fatal cases caused by plant poisoning are very rare in Florida in spite of numerous potentially poisonous plants, but it can occur. The physician must consider each patient exposed to such plants a potential risk and herein lies the perplexity. The history is frequently inadequate, the physical may show nothing and there are no diagnostic tests to help identify or quantitate the potential plant poison. To help prepare the physician for such problems the remainder of this article will focus on statistics of plant poisoning in children and some specific plants frequently encountered in Florida.

Frequency of Plant Poisoning in Children

The frequency of plant poisoning in children is unknown. Children with symptoms of toxicity may be misdiagnosed if the parent is unaware of plant exposure. The symptoms may mimic more frequent medical entities. Patients with a positive history of exposure to plants may seek only telephone advice and treatment. Some patients may actually see a physician or be treated in the emergency room or in the hospital but statistics may not be kept or reported to the National Poison Control Centers. The most recent national tabulated reports[1] of potential poison from plants accounted for 5.6% of the total reported in 1975 and 6.9% in 1974. internal medications continued to top the list of reports. Household cleaning agents took second place in 1975. Plants were in third place.

Since statistics are incomplete and plant poisonings vary from one state to another, it may help prepare the physician in Florida if he reviews the cases seen on a large pediatric service. The University of Miami Jackson Memorial Hospital in Miami, Florida, is a large urban teaching hospital serving all of south Florida. Patient statistics were analyzed in four separate categories: phone inquires (adult and children), emergency room patients (0-14) years of age), hospitalized patients (0-10 years of age), and Dade County Medical Examiner cases (0-14 years of age).

Telephone Inquiries

The Poison Control Information Service located in Jackson Memorial Hospital is provided by the pharmacy 24 hours a day seven days a week. The phone number is listed in "emergency numbers" of the phone directory. Lay and professionals from south Florida call for information.

The average number of recorded phone calls to the center is 350 per month. A total of 4,200 consecutive reports (all ages included) over a 12-month interval was reviewed. Possible plant poisoning was noted in 385 calls (9.1% of total calls). At least 70 varieties of plants were recorded. Table 1 indicates the most frequent plants encountered. These figures may not represent a true incidence of plant poisoning but do reflect plant questions received by the Poison Center. Recorded information was inadequate to separate persons calling for educational information, because of signs or symptoms of poisoning or cases necessitating medical care other than first aid.

When ages of patients were recorded the most frequent was one through five years. The very young

Table 1. — Most Frequent Plants Encountered By Phone Reports.

Frequency	Common Plant Name	Spanish or Cuban Name	Number Cases
1.	Brazilian pepper	Pimienta Roja, Copal	43
2.	Dieffenbachia	Dicha, Mata Puerco, Canne Madere	32
3.	Rosary pea	Santa Juane; Peonia	18
4.	Pencil tree cactus	Polito Chino; Antena	16
5.	Ficus	Laurel; Jaguey	14
	Mushroom	Hongo; Setas	14
	Poison ivy	Guao	14
	Cactus	Tuna, Cardo, Cacto	14
6.	Oleander	Adelfa; Rosa de Francia	10
	Philodendron	Malanga	10
7.	Ixora	Isora, Santa Rita	10
	Allamanda	Copa de Mantequilla	9
8.	Poinsettia	Flor De Pascua	8
9.	Coral plant	Pino de Coral	7
10.	Balsam pear	Cundeamor	5
	Angel's Trumpet	Chamizco, Compana de Angel	5
	Bischofia	Bischofia	5
11.	Hibiscus	Mar Pacifico	4
	Sea grape	Uva Caleta	4
	Crown-of-thorns	Gracia De Dios; Corona De Cristo	4
	Croton	Croto	4
	Bottle brush	Bigote Gato, Cepillo de Botella	4
	Mango	Mango	4

child (less than one year of age) appeared to be at greatest risk for eating plant leaves. Calls about unidentified berries presented a significant management problem necessitating referral to a local botanist or medical service. There are numerous popular red, blue, green, or orange berries abundantly available in south Florida. The most frequent one encountered was brazilian pepper **(Schinus terebinthifolius)**, also called Florida holly. The rosary pea was second.

The National Clearinghouse in 1975 reported philodendron in first place for 1975[1] (Table 2). It is obvious that south Florida flora differs greatly from other regions and that potential plant poisoning varies equally. Brazilian pepper grows wild in Florida. Its red berries attract children who probably associate the color with edible fruits. Rosary pea is abundant in waste places and its colorful firm seed is used in necklaces, rosaries or toys (bean bags). The rosary pea has proved to be responsible for most hospital admissions and the only plant causing deaths in children in Florida during the last few years. (However, see accompanying article on Angel's Trumpet poisoning, this issue—Ed.)

National statistics indicate poinsettia **(Euphorbia pulcherrima)** in fifth place but it placed eighth locally where it is abundant. Perhaps parents and physicians locally are aware of its low toxicity and infrequent calls are received at the Poison Center. Information about this popular plant's human toxicity is limited and controversial but is summarized next.

Poinsettia Toxicity

The literature on the toxicity of the poinsettia **(Euphorbia pulcherrima)** leaves the clinician confused. The reported death of a 2-year-old child in Honolulu in 1919 by Dr. H. L. Arnold was said to have been retracted by the physician prior to his death but the case continues to be quoted. In 1965 a 2½-year-old child in Rochester, New York, was reported to have been seriously ill after eating a leaf of poinsettia. A request was made to the Consumer Products Safety Commission in 1975 requiring warning labels on poinsettias which was denied. In 1976 L. Ferrero noted in "Lady's Circle" that the poinsettia was "responsible for deaths of countless numbers of children." This kind of information has alarmed the public and continues to plague the Poison Control Center and physicians. Dr. R. F. Chittenden in the "Poison Penletter" in January 1975 noted that poinsettia is minimally hazardous around Honolulu where it grows abundantly. Dr. Charles L. Winek related in "The Toxicology Newsletter" in December 1975 that the poin-

Table 2. — Tabulation of Plants Encountered in Decreasing Frequency.

Plant Phone Calls-Miami	Plant Totals Reported — National
1. Brazilian pepper	Philodendron
2. Dieffenbachia	Pokeweed
3. Rosary pea	Holly berry
4. Pencil tree cactus	Pyracantha
5. Ficus	Poinsettia
Mushroom	
Poison ivy	
6. Oleander	Dieffenbachia
Philodendron	

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settia is not toxic. He calculated the LD_{50} dose to be greater than 25 grams/kilogram. He theorized that a child would have to eat 1¼ pounds of leaves to get sick. A leaf weighs about one gram. He felt detailed studies on its toxicity in humans were necessary and was testing the contact aspects of it in his laboratory. Dr. Jay Arena at Duke University and others have reported a number of ingestions but noted only a mild local or intestinal reaction. In Miami it is abundant in yards, but we have had only eight phone inquiries in one year and have not seen it cause a serious problem in a child in the emergency room or in the hospital during the last 17 years. Records in two other local hospitals in Miami have indicated no child was admitted who had ingested poinsettia in the last five years.

Dr. Julia Morton of the Morton Collectanea, University of Miami, who is a nationally recognized expert on plants, says that certain growing conditions may effect potential toxicity of individual poinsettia plants and that further studies will be necessary in humans.

Perhaps the child samples minute quantities, vomits the ingested material or deactivities the toxalbumin in the GI tract and clinically expresses mild toxicity. At the present time there is agreement that the poinsettia may cause a local dermatitis, the sap may cause a burning sensation of the eyes and mouth and it may cause a mild gastroenteritis. It is clinically apparent that children do not get ill enough to be treated in hospitals from poinsettia ingestion. At the present time one would consider administering ipecac after an ingestion to eliminate possible sprays or contamination of the plant and other plants thus eliminating the perplexity of waiting for possible toxicity in any given patient. Even though toxicity appears minimal, poinsettia is not recommended for a Christmas punch float or the salad bowl!

Emergency Room Cases

A study of poisoning in children was conducted over a three year period in the Pediatric Emergency Room at Jackson Memorial Hospital in Miami. About 30,000 visits per year were recorded. Possible poisoning was the working diagnosis in 1,124 cases (3.7% of the total children under 14 years of age). Table 3 indicates the most frequent ingestions in decreasing order of frequency. Plants ranked in eighth place in frequency. Other surveys over the country indicate plants in third, fourth and seventh position and account for 5%-6% of the total poisonings.

Table 3. — Emergency Room Visits for Possible Poisoning.

		Cases
1. Internal medications		455
Salicylates	95	
Valium	33	
Tranquilizers	28	
Anticonvulsants	22	
Birth control pills	18	
Narcotics	15	
2. Bleach		125
3. Hydrocarbons		116
4. Household products		103
5. Rat poisons		49
6. Insecticides-repellants		43
7. Alcohol		42
8. Plants		34
9. Caustics		22
10. Cosmetics		18
11. Others		117
Total		1124

Plant poisoning was suspected in 34 patients (3.0% of suspected poisoning cases). Table 4 indicates type of plant material suspected by history. The list does not reflect a pure incidence of plant ingestions in the community but indicates what types present problems and referrals. The largest number of cases had unidentified berries or plants by history. These cases were referred by Poison Control phone service, local M.D. or self referrals because of unknown as well as known potential poisoning.

Table 4. — Emergency Room Patients Suspected of Plant Poisoning.

Types of Plant Material	Number Cases
1. Berries (unidentified on chart)	16
2. Plant (" " ")	4
3. Seeds (" " ")	3
4. Rosary pea	2
5. Coral plant	1
6. Elephant's ear	1
7. Physic nut	1
8. Florida holly	1
9. Ixora	1
10. Spanish lime	1
11. Sunflower seeds	1
12. Croton	1
13. Pea	1
Total	34

Most patients suspected as poisoned from history of plant exposure were asymptomatic. All these patients were given ipecac (unless administered prior to arrival) regardless of potential toxicity of the ingested plant. This assured removal of large quantities of plant material, unidentified material such as spray, other plants and medications. Ipecac was administered by the nurse. This was followed by 200 cc (avoid over distention of stomach) of water given by the mother. Most patients vomited

before 20-30 minutes. A second dose was required in only a few patients.

Ipecac* proved to be reliable, safe and effective as reported in several studies in children.[2-7] These reports indicated: (1) it is premixed, available and easy to administer; (2) average time for effect was 17 minutes; (3) 98% of patients respond to usual dose of 10 cc for less than one year of age, 15 cc for 1-12 years of age, 20 cc for greater than 12 years of age; (4) the dose could be repeated if necessary after 30 minutes if no vomiting ensued and (5) the central stimulus and the gastric irritant effect produce better stomach evacuation than lavage.

Hospital Admissions

The pediatric admissions during five years (1971-1976) at Jackson Memorial Hospital showed 204 were for possible poisoning (6.5% of total admitted). Only nine patients were admitted for possible plant poisoning (4% of total poisonings). Table 5 indicates the suspected plants ingested and the number of patients involved. Brief case summaries are presented.

Table 5. — Pediatic Hospital Admissions for Plant Poisoning:

Plant	Number Patients
Rosary pea	5
Coral plant	3
Mushroom	1
Total	9

Rosary Pea Cases

Case 1. — A 5-year-old white male was playing in the backyard at his grandmother's. He was seen with a rosary pea in his mouth and was told to spit it out. He said he did but because of potential toxicity and mild vomiting he was referred for admission. Ipecac was given but no rosary pea was noted in the vomitus. He was asymptomatic in the hospital for 24 hours and remained so after discharge.

Case 2. — A 3-year-old black male vomited at 2:30 p.m. His brother reported he had seen the patient with a rosary pea. He was referred for observation and was found to be drowsy. In the hospital he had a benign course.

Case 3. — A 10-year-old white boy was transferred from another hospital after chewing and swallowing a rosary pea. He vomited two times in one hour. Ipecac was administered. He was alert, IV was started and calcium gluconate was administered. No signs of any symptoms occurred during his three day hospitalization.

Case 4. — A 1½-year-old white female was found one hour prior to arrival in the Emergency Room with a rosary pea in her mouth. The mother related that the child had bitten the poisonous seed which was taken from a necklace but no symptoms were present. Ipecac was effective but no seed component was present in the vomitus. She remained asymptomatic.

Case 5. — A 2½-year-old was chewing a rosary pea prior to onset of vomiting three times. Ipecac was administered to assure complete stomach evacuation. No pea was apparent in the vomitus and she remained asymptomatic during the next 24 hours.

Coral Plant

Three children age 3 at their grandmother's house ingested coral plant leaves and seeds at 3:00 p.m. All the children started vomiting one half hour later and continued to do so two to three hours. They were admitted and treated with Maalox alternated with Gelusil. The electrolytes were normal and the patients were discharged in 24 hours. They remained asymptomatic.

Mushroom

A 2½-year-old white male vomited after lunch, became limp and was treated in the referring hospital with atropine and PAM. Pieces of mushroom **(Teprota morganic)** were found under his swing set. He was reported to be lethargic, hallucinating, febrile and with dilated pupils prior to helicopter transport to the teaching center. He gradually improved over two days.

Discussion

It is difficult to know how much if any of the suspected plants was ingested by these patients. All of them presenting with symptoms had a history of sudden onset of vomiting and possible exposure to specific plants. None were very ill and all were given simple supportive treatment. The physician should consider ingestion occurred and toxicity could develop. Ipecac should be administered to assure stomach evacuation in all exposures to toxic plants, especially rosary pea.

Medical Examiner Cases

All pediatric cases in the Dade County Medical Examiner's office were reviewed over the last 20 years (1956-1976). Table 6 indicates the 69 who died of poisoning.

Only two died of plant poisoning. The rosary pea was responsible for both expirations.

Case 1. — A 2½-year-old black female had sudden onset of vomiting at 6:45 p.m. She was seen playing with a rosary pea earlier but it was unknown whether she ate it. She was seen at two hospitals four times over the next three days for vomiting, diarrhea and abdominal pain. A diagnosis of gastroenteritis was made. She had a convulsion, became unconscious and expired before the diagnosis was made and confirmed by the Medical Examiner. The rosary pea was in her yard and she had been told by parents and friends that it was "bad." The mother related seeing red material in vomitus but that could have been from pimento in potato salad consumed that day.

Case 2.—A 2½-year-old white male had acute gastroenteritis similar to other members of his family for four days but was not ill enough to seek medical attention. He had a little blood stain in his under clothes. He had been seen with a plastic jug filled with unripe rosary peas from a hedge in the backyard. He awoke at 5:00 a.m.

*See note at end of article concerning Ipecac Interference with toxicologic analysis.—Ed.

Table 6. — Deaths Due to Poisoning, 1956-1976

Children < 10 years of Age Dade County	
1. Organic phosphate*	20
2. Salicylate	12
3. Hydrocarbon, etc.	10
4. Carbon monoxide	6
5. Barbiturate	3
6. Phosphorus*	3
7. Rosary pea	2
Lye	2
Arsenic*	2
8. Iron	1
Dia-cut coolant	1
Methylene chloride*	1
Strychnine	1
Hydrofluorine	1
Ethyl alcohol	1
Antimony	1
Ipecac and ASA	1
Narpramin	1
Total	69

*Pesticides (43% Cases)—See separate article, this issue.

not feeling well but ate toast and played with the cat until he went to sleep. At 8:30 a.m. he was found pale, unreponsive and was dead on arrival at the emergency room at 9:05 a.m.

The autopsies revealed typical findings caused by the rosary pea as described by Dr. Joseph Davis in this journal.

Discussion

Both of these cases had a history of exposure to the rosary pea but the diagnosis was not made before the children expired. In the first case the physician made an error in not suspecting poisoning in the presence of history of exposure, sudden onset of vomiting, history of red material in vomitus and unexplained convulsive activity. All physicians involved said the patient did not look sick.

In the second case the family misjudged severity of illness and delayed seeking medical care since other members of family and church had gastroenteritis signs. Sudden onset of vomiting is a prominent presenting sign of poison and the history of availability and exposure to a toxic plant should have led to the proper diagnosis prior to death. Since this is the only type of plant known to have killed a child in Florida in the last few years, it is strongly recommended that any child found playing with or having a history of exposure to the rosary pea have his stomach evacuated immediately. When in doubt, always error on the side of over reaction to this plant. Obviously, this viewpoint demands education of the public so the patient is brought to a medical facility. To wait for symptoms is too late in that there is no treatment except supportive care.

Summary

The exact incidence of plant poisoning in Florida is unknown and toxic plants vary from one environment to the next. The problem of inadequate history and potential toxicity is never clear when treating the young child who is most at risk for accidental plant poisoning. A survey at a large pediatric service indicated 9.1% of total phone inquiries was about plants; the most frequent calls were related to brazilian pepper, dieffenbachia and rosary pea. Three percent of children treated in the emergency room for poisoning had suspected plant exposure. Four percent (9 of 204 cases) of children admitted at the hospital for poisoning had plant ingestion. The rosary pea was suspected in 55% (5 of 9 cases) admitted for plant poisoning. All eight symptomatic cases admitted had vomiting as the predominate symptom. Only two cases of 69 deaths due to poisoning in children died of known plant poisoning over the last 20 years in Dade County. Both children died before the diagnosis of rosary pea poisoning was made.

Conclusion

The physician should suspect poison if a perfectly well child suddenly presents with vomiting.

He should be aware that a number of plants in Florida have potential toxicity.

He must obtain a careful history of exposure to possible plants and encourage the parent to bring in the plant leaf and fruit for identification.

Most plant exposure does not cause severe medical problems but every case must be carefully evaluated.

The rosary pea causes the most life threatening medical problems and every effort should be made to eradicate it in public dwelling areas. When a child has had a possible exposure to the rosary pea it should be assumed he chewed it and emesis should be produced as soon as possible.

He should be aware of the most frequent toxic plants in his catchment area and have reference material at hand about them. (See Dr. Morton's excellent book and charts and Dr. Lampe's book.)[8,9]

He should counsel parents about prevention of plant poisoning and encourage them to be familiar with all plants in their house, yard and neighborhood.

He could make a home visit to detect potential poisons and accentuate his interest in keeping the child and family healthy and happy.

Prevention of plant poisoning provides freedom of perplexity for patient and physician. Keep posters of poisonous plants in the office. A constant reminder to the physician and parents is good cheap insurance.

Acknowledgement

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Note on Use of Ipecac

Although the administration of ipecac is a very important medication in the treatment of suspected poisoning, the presence of ipecac wrecks havoc with attempts at toxicologic analysis. If toxicologic analysis of gastric material is to be submitted, it is important to obtain a specimen, if at all possible, prior to administration of ipecac. However, the administration of ipecac and its presence in the specimen material need not prevent toxicologic analysis. If ipecac is present in the submitted material, the toxicologist should be informed of this, so that he can take appropriate measures in his analytical procedures. See additional discussion of this problem in another article in this issue, "Poisonous Plants and the Toxicology Laboratory". — Editor (L. E. McHenry, M.D.)

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Plants of Importance in North and West Florida

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Abstract: The following plants are described: oleander, dumbcane, castor bean, mistletoe, and tung nut. Treatment of these plant poisonings is described.

Plants have been demonstrated as significant in human poisoning. Considering the number of plants containing toxic substances and their attractive appearance, it is surprising that there are not more reports of plant-substance intoxication.[1] Currently the greatest number of reported poisonings are not "accidental" in young children and are deliberate in young adults.[2] This may be due to small quantities ingested, relative unpalatability and insolubility of outer surfaces of leaves, stems, berries and nuts. Older individuals are attracted to plants reputed to have mind-altering effects.

The most important aspect of handling plant ingestion is induction of vomiting to remove the material from the alimentary tract.

The following plants are some of those most often known to be ingested by children in north and west Florida.

Oleander

Nerium oleander is common oleander, a woody shrub or small tree ranging in height from five to 25 feet (photograph No. 33). When allowed to grow naturally, it produces a large clump of stems but occasionally plants are trimmed to a single large trunk with a large branched crown. The bark on young stems is smooth and green but older branches and trunks are gray and rough. The leaves usually turn yellow before falling. The flowers are produced in early summer or all year in the warmer parts of the state. They vary in color from white through pink, creamy yellow and rose to deep red. All parts of the plant. but especially new growth, exude a gummy, sticky sap when injured. The oleander is an exotic plant found only where it has been planted.

All parts of the plant are poisonous if eaten, whether green or dry. It has been reported that one leaf is sufficient to kill an adult human and that smoke from burning plants, when inhaled, may produce toxicity. This, however, has not been documented. It has been stated that individuals have become poisoned after eating meat or frankfurters suspended by sharpened oleander stems over a fire. This may be folklore but deaths have been reported of eight of 12 French soldiers who cooked their meat ration on oleander sticks during the Napoleonic campaigns in Spain in 1808.[3] The report of similar occurrences in Hawaii has not been confirmed.

Dermatitis may be caused by contact of the bare skin with any part of the plant.

Two toxic glycosides, oleandroside and nerioside, with properties similar to cardiac glycosides, have been isolated from these plants. They produce nausea, vomiting, abdominal pain, central nervous system depression, evidence of decreased cardiac function, with irregular pulse, dilatation of pupils, bloody diarrhea, respiratory paralysis and even death.

Recommended treatment has been atropine as well as induction of emesis and symptomatic supportive measures.

Yellow oleander, **Thevetia peruviana,** lucky nut or tigerapple, found chiefly south of Orlando is a tropical, exotic ornamental not truly an oleander. It is toxic in all parts but very unpalatable. Two deaths from ingestion of the fruit have been reported from Hawaii.

Dumb Cane

Dumb cane, **Dieffenbachia seguine** or **picta,** is a tender house plant (photograph No. 36). The green stems, three to six feet tall, are fleshy about one inch or less thick. The leaves are borne on leaf stalks. Their basic color is green but many horticultural forms are variously spotted, streaked or mottled with white, lighter or darker green, or yellow-green. Some varieties are green only on the margins and midrib. The inconspicuous flower-parts look like a tightly rolled green or spotted leaf two to four inches long enclosing the very small, true flowers. Dieffenbachia is native to tropical America and has been cultivated as a greenhouse of conservatory plant in this country for over a hundred years. It can be planted outdoors in warmer parts of the state and is frequently used as decoration in public buildings.

All parts of the plant are toxic. There is a toxic protein material but the major source is the numerous calcium oxalate crystals in the plant tissues. Chewing and swallowing the material results in swelling and burning sensation of the throat, tongue, interior surfaces of the mouth and lips, resulting in difficulty in speaking and much salivation; thus the appelation "dumbcane." Theoretically one should

be concerned about the possibility of respiratory airway obstruction although this has **not** been reported.

Slightly alkaline, topical substances act as a demulcent. Otherwise the treatment is avoidance or tincture of time.

Castor Bean

Castor bean, **Ricinus communis,** is an annual herb growing to the size of a small tree primarily in south Florida (photograph No. 13). It may appear in other sections of the state in sheltered areas. The strong stems are four to ten feet tall, erect, frequently crooked, green or red to purple in color, and sometimes covered in a white waxy coating. The flowers, produced in narrow, upright clusters, six to 12 inches long, are greenish-white or reddish-brown about a half inch across and like petals. Their fruits are erect, oval, green or red, and covered with stiff fleshy spines. There are three in each pod about one-half inch long.

Castor bean contains a poisonous protein, ricin, as well as ricinoleic acid and oleic acid. All parts of the plants are toxic but the main source of poisoning is the seeds, the most appealing part. The symptom is a burning sensation in the mouth and throat; subsequently, there are signs of irritation of the gastrointestinal tract, resulting in intense nausea, vomiting, abdominal cramping, bloody diarrhea, and symptoms secondary to dehydration and shock. It has been estimated that as few as eight seeds may constitute a lethal dose.

Mistletoe

Mistletoe, **Phoradendron flavescens,** has been reported as causing the deaths of several children who ate the berries and adults who drank tea brewed from the berries. Berries are the only toxic parts; substances are beta-phenylethylamine and tyramine. The symptoms are due to those adrenergic compounds and present as gastroenteritis, about ten hours after ingestion, and possible subsequent cardiovascular collapse.

Mistletoe is a parasite which actually invades the tissues of other plants usually trees such as pecan, oak, cherry laurel, and dogwood. It appears to avoid pine trees. It is really not available to most people but parts may be used as decorations during festive occasions.

Tung Nut

Ingested tung nuts have been frequently the cause of poisoning in north and central Florida. These nuts come from the tung tree **Aleurites fordi.** This is a small deciduous tree with smooth bark. Native to China, it has been imported into this country as a source of oil for commercial use and early during this century many plantings were made along the gulf coastal plain. This is apparently no longer economically profitable and the large plantations have fallen into ruin around Gainesville and Tallahassee. There are still quite a few tung trees planted for shade.

The nuts are attractive and fresh ones taste like chestnuts, stored ones like almonds with a rancid after taste. The nuts are within fruit about four to six cm in diameter and beginning dark green, later turning brown as maturation occurs. Each contains three to seven large, hard, rough-coated seeds resembling walnuts. They have a white flesh. No other portion has been reported ingested by humans, although other parts of the tree are toxic to cattle.

The symptoms are primarily those of severe gastrointestinal irritation—nausea, vomiting, abdominal cramping and intense diarrhea with severe dehydration, shock—and potentially renal failure.[4]

Treatment consists of removal of ingested materials, careful monitoring, supportive and replacement fluid therapy.

General Principles of Treatment

As with most types of poisoning, the most important aspect of treatment is removal of the substance, and time is of the essence. The quickest and most efficient way to remove any type particulate matter from the stomach is by causing vomiting either mechanically or chemically with syrup of ipecac or injections of apomorphine. Activated charcoal may be used to adsorb toxins. Whether or not purgatives are effective has not been documented.[5]

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Citrus Eye Disease

Herbert E. Kaufman, M.D.

Abstract: A description is presented of fungus keratitis due to infection with filamentous fungi such as Aspergillus and Fusarium fostered by vegetable injuries. Diagnosis and treatment are discussed.

Fungus keratitis is not common in the United States and Canada. I have estimated that there are approximately 300 cases a year; probably between ¼ and ⅓ occur in Florida. This is a direct function of our climate which favors the growth of fungus on plants and other vegetable matter, and appears also to be a function of our agricultural economy.

There are basically two kinds of fungus infections that affect the cornea of the eye. In some tissues that are devitalized from chronic infection, treated heavily with corticosteroids and often antibiotics and have epithelial ulcerations, infections with yeasts, especially Candida, are the most common. Yeast infections are generally seen in the northern areas of our country.

In areas like Florida, however, infections with the filamentous fungi such as Fusarium and Aspergillus which have predominantly mycelial forms are fostered by vegetable injuries. Infections certainly can occur in the absence of corticosteroid treatment but treatment with corticosteroids does appear to make fungus infection dramatically worse, and general physicians who see patients with ocular vegetable injuries should be aware of this fact. In the past, such infections were most common in workers who drove tractors down the lanes between trees in orange groves. When safety glasses or goggles were not worn, injuries caused by leaves slapping the eye were not uncommon. If medical care was sought, often it was sought from a practitioner not aware of the problem and corticosteroids were used which could make the problem much worse. In our experience, it seems apparent that simple precautions such as wearing safety glasses by anyone driving exposed in a vehicle in such an area can dramatically reduce the incidence of this condition. In addition the realization that corticosteroids may be harmful would help our patients. Of course local anesthetics which often severely damage the cornea as well as masking symptoms and delaying care should never be given to the patient for his use.

From the Department of Ophthalmology, University of Florida College of Medicine, Gainesville.

Diagnosis

The diagnosis of ocular fungus infection is more complicated than it seems. The clinical manifestations, although not pathognomonic, tend to be typical. The ulcer, which is small, may have irregular hairy borders which are not usually seen with bacterial infections. These "hyphate margins," as we have called them, are often accompanied by a rather severe iritis but very little purulent discharge. Satellite lesions around the main ulcer are also relatively common (Fig. 1). Other less common manifestations of fungus infection, but those still typical of this condition, include plaques on the corneal endothelium, very elevated heaped-up ulcers, and rings of immune precipitate around the ulcer.

The history of injury with vegetable matter and the appearance should indicate to both the ophthalmologist and the general physician the possibility of fungus infection. When this suspicion arises, laboratory confirmation should be undertaken.

Simply scraping the edge of the lesion with a sharp blade to remove some material for examination of either potassium hydroxide or even saline preparations allows the fungal elements to be seen. Gram (Fig. 2) and Giemsa stains as well as more specialized stains can also be used.

Culture of the lesions requires that the general physician understand that the fungal culture media usually available to him contains inhibitors of the "nonpathogenic" fungi. These inhibitors prevent growth of the most common fungi that attack the eye. If Sabouroud's media is to be used, it should not contain chlorhexidine or other inhibitors. Cultures should be stored both at room temperature and at 37 C. Beef heart infusion and simple blood agar may also be effective, although in some ways slightly less desirable.

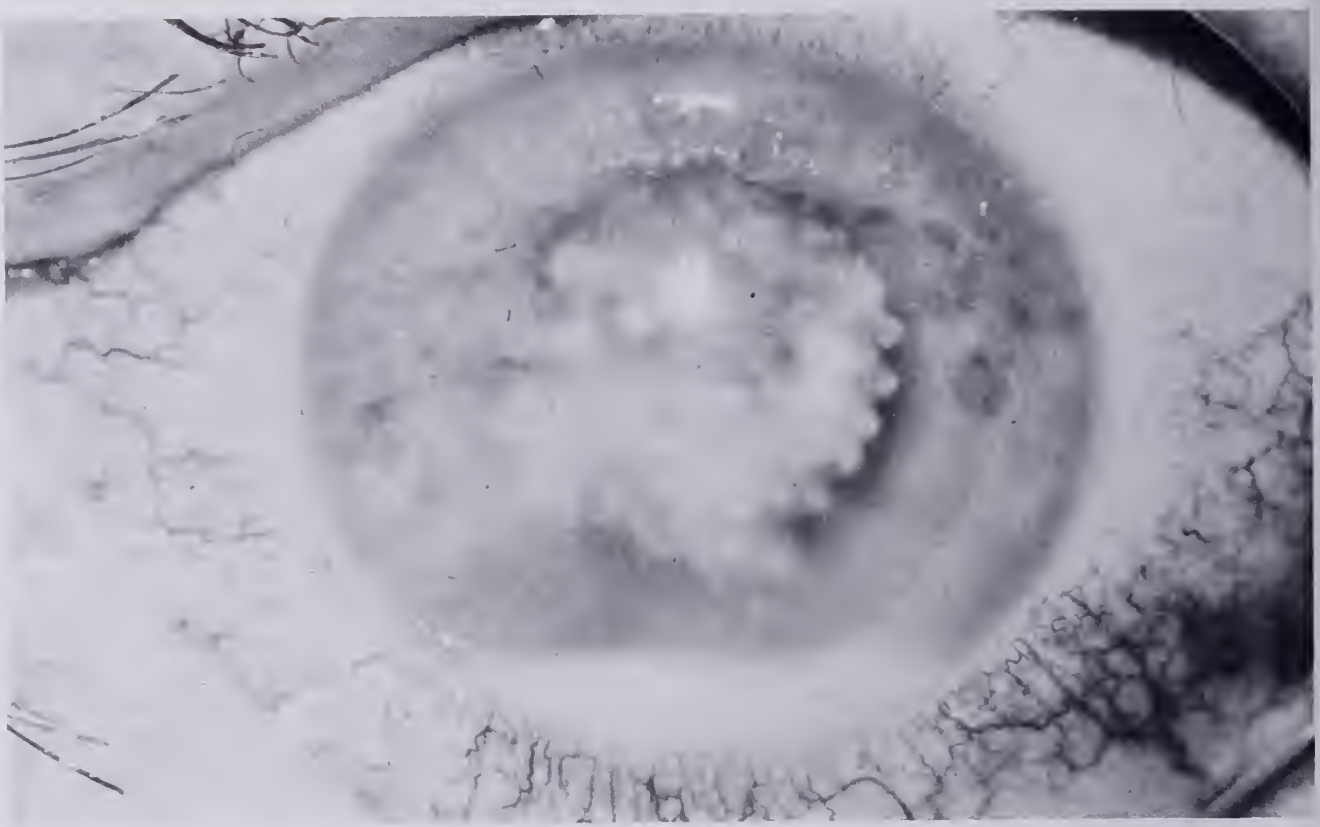


Fig. 1. — Fungal ulcer of cornea with satellite lesions and a hypopyon.



Fig. 2. — Gram stain of scraping taken from margin of corneal ulcer showing fungal hyphae (400 X).

Treatment

Once the diagnosis of fungus keratitis is made, the patient should clearly be in the hands of an ophthalmologist. In terms of therapy, the drug of choice as the initial treatment for fungus keratitis is pimaricin (Natamycin). Because of the small number of cases and the peculiarities of our drug regulatory system, such a great loss would be experienced by any company clearing such a drug through the FDA and making it available that the drug is not yet commercially available. The university in Miami and L.S.U. Eye Center however, do have pimaricin which can be sent to physicians if diagnosis of fungus keratitis is proven.

No drug is uniformly effective, and pimaricin is no exception although its efficacy is great. If infection of the cornea progresses, a corneal transplant to remove the infection which is not responding to the treatment or use of newer experimental drugs may be necessary. One of the important aspects of therapy for the general physician is the realization of how small the optical area of the cornea is, and how little advancement of infection is required for damage to be permanent. Scarring even if healing occurs, can result in a permanent opacity. Because of this, a high index of suspicion and very early diagnosis and initiation of therapy can often prevent blindness or the need for later corneal transplant surgery. Certainly this recognition may minimize the use of drugs such as corticosteroids which can exacerbate and hasten the destruction done by this process.

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Indirect Lethal Ramifications of Horticulture

Joseph H. Davis, M.D. and Ronald K. Wright, M.D.

Abstract: Indirect adverse reactions to plants are derived from products of plant metabolism, economic poisons used in agriculture, infections secondary to injuries while engaged in horticulture, and mechanical and electrical injuries associated with the cultivation of plants. Most prominent are poisonings by pesticides: parathion, organophosphates, nicotine sulphate, paraquat, and arsenicals . Hydrosulfide is produced by plants, anerobic bacteria, and rotting vegetation. Plant products used for illicit intoxicating effects can cause morbidity and mortality: heroin, cocaine, marijuana, and alcohol. Injuries by falls and other accidents occur occasionally as indirect results of horticulture.

This special issue of the Journal is replete with reports of direct toxic and physical injuries to be expected from interaction of man and his plant environment. Untimely deaths have been intensively studied for over two decades in Dade County. Within these 65,000 deaths are those which arose from indirect association with plants. These include toxic exposure to products derived from plant metabolism, from economic poisons used in agriculture, from infections secondary to injuries while engaged in horticulture, and from mechanical and electrical injuries associated with the cultivation of plants.

Most prominent have been poisonings by pesticides used in agriculture. During the early 1960's 10% of the approximate 100 annual Dade County poison deaths were caused by pesticides.[1] In Dade County 250,000 pounds of parathion preparations were used in 1964. This was sufficient to kill every human being on the face of the earth if distributed equally to all. The poison was so cheap, unrestricted, and common that we encountered gallon glass containers of 80% concentrate in suburban homes! Itinerant nonlicensed illegal pest control operators would "fumigate" a home for roach control by sprinkling a few pennies worth of the chemical about the baseboards on the floors. As the result of carelessness in distribution it became a truism that a small Negro toddler which began to cry, stagger, collapsed and was dead or dying on admission to the hospital was a case of parathion poisoning until proven otherwise.[2] Dade County was selected as one of the nation's Community Pesticide Study Centers and, today, under the aegis of Dr. John E. Davies of the University of Miami School of Medicine we enjoy an international reputation as a center of learning in the field of chemical epidemiology while no longer repeating the mistakes of yesteryear.

Although organophosphates ranked supreme in their lethal abuse, other interesting pesticide deaths occurred. Nicotine sulphate extract is an insecticide derived from the tobacco plant. In our experience deaths would occur within seconds of ingestion, one of the most lethal poison results ever observed. Nicotine sulphate leaves few autopsy clues for the unwary and inexperienced pathologist because the newer preparations lack the rank offensive odor of the material that was distributed for home garden use during the 1930's. The lungs are noted to be intensely congested as are the bronchi which exude a mild increase in mucous. An ultraviolet absorption curve on gastric juice and blood may reveal an unusual concentration of nicotine well above that which results from smoking or chewing tobacco.[3]

Paraquat, a commonly used herbicide, is interesting in view of its selective metabolic concentration in lung tissue following ingestion. This results in a most pronounced fibrous solidification of the lung often with epithelial proliferation within terminal bronchi.[4] Current emergency therapy of paraquat ingestion demands vigorous treatment with bentonite introduced into the gastrointestinal tract. The Chevron Company maintains an emergency telephone service for the physician desiring assistance in treatment, (415) 233-3737. Lack of clinical appreciation results in confusion when clinical poisoning arises. In one of our paraquat cases the victim was sent to the state hospital in Lantana as suspected tuberculosis. In another, a homicide, several hospital transfers ensued before the diagnosis was suspected.

Arsenical nonselective weed killers have resulted in nonintentional as well as intentional deaths. The family of one outstanding nursery man was severely

poisoned by the use of a contaminated plastic jug for drinking water. In fact, careless use of beverage containers for pesticide distribution has been a continual problem both here and abroad.

Agriculture spray planes have crashed while attending to the needs of plants. Toxic pesticides are expected to contaminate the crash site, a hazard to rescue workers, police and firemen. A different hazard became obvious in one circumstance when the 2,500 pound cargo of ammonium nitrate fertilizer detonated in the post-crash fire severely injuring a police onlooker.

Hydrogen sulfide is produced by plants, anerobic bacteria, found in rotting vegetation. Hydrogen sulfide deaths occur when ditches are being dug through such ground especially when there has been a previous overfill of impervious soil.

Bacterial infections may be attributed to the plant kingdom. Two rather unique infections have been seen among our horticulturists. The first was a prominent garden club leader who was stung on the dorsum of the foot by a bee while gardening. Unbeknown to her and the physicians who subsequently became involved, the sting involved a vein which became thrombosed for a distance of only two millimeters. This provided the nidus for tetanus bacilli to proliferate. Another quite indirect case was that of a nursery man who developed a pustule on the dorsum of his hand following a minor injury. Another pustule appeared farther up the forearm and yet another which would not respond to antibiotic therapy. He became depressed and shot himself in the head. The medical examiner diagnosed sporotrichosis, a readily treatable condition if potassum iodide had been substituted for antibiotics. An unusual manifestation in this case the demonstration of the organisms in stained smears of the pus without the usual necessity of animal passage.

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Elsewhere in this issue is a discussion on the toxicology of mushrooms including their hallucinogen effect. Our case was an intoxicated young man who wandered into a wet field to gather his toadstools, apparently passed out and drowned in only a few inches of water.

Plant products for illicit intoxicating effects have been associated with deaths on a regular basis. Noteworthy is heroin where we encounter about two dozen deaths per year in Dade County. Occasionally seen is rapid death from cocaine mixtures ingested in condoms by ill-intentioned youths returning from Bogota, Colombia. The cardinal sign of such a death is a laxative container alongside a dead body in a motel near or at the airport. These people do not realize that condoms are porous to water in gastric juice and act as dialyzing membranes. The contents swell until they burst. The results are catastrophic.[5]

Marijuana is big business, so much so that the "busts" along the Gold Coast are measured in tons. With this much around we may expect to encounter adverse results in drivers or others engaged in hazardous occupation or sport. Tests have indicated the adverse effects upon drivers utilizing the public highways.[6] Most unusual was the sport parachutist who apparently gave himself a long marijuana count and failed to deploy his parachute until too late. Unfortunately we lack laboratory expertise to readily measure the distribution of this drug and its products in our victims of violence and must rely upon circumstantial evidence. Alcohol, on the other hand, is of such little comparative toxicity that relatively vast amounts are needed to intoxicate. This facilitates laboratory demonstration. Alcohol, incidentally, is the result of fermentation of plant products by other plants, yeasts.

Machinery used in agriculture is hazardous. Most frequently observed are deaths due to electrocutions. Improper maintenance or use of electrical hedge trimmers or grass mowers result in deaths. There are larger numbers of victims who become electrocuted while trimming branches in the vicinity of high tension distribution lines or while moving trees with winches under high tension lines.

Lethal falls from trees occur, one or two a year. These usually involve the elderly homeowner who has cared for his pet mango or avocado tree for many years and has failed to realize the handicap of age while rendering such care.

Finally the ultimate in indirect adverse reactions involving plants are those homicides which have occurred in arguments over mangoes or shoot-

ings erupting as a result of depredation of commercial groves by thieves. From these spring civil litigation, if it is the bad luck of the thief, for his death then becomes the bad luck in civil court for the outraged grower.

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Florida Academy of Family Physicians

Poisonous Plants and the Toxicology Laboratory

Judith E. Loebel, M.T., B.A.

Abstract: This article is a comprehensive overview of techniques and analytic methods useful in a modern toxicological laboratory. Precautions of submission and proper submittal information, which should accompany specimens, are also discussed.

It is indeed ironic that many of the plants used widely for subtropical landscaping as well as those grown as decorative house plants can be as dangerous as they are beautiful. Uncultivated species as well contribute to the vast list of plants known to possess toxic properties, which may become fatal if ingested by man. This abundance of readily available, potentially toxic material is a source of great concern to the toxicology laboratory since it causes unique problems in isolating the causative agent in poisoning cases.

Plant-induced poisonings fall into three main categories. First are those cases which are accidentally caused by an unfamiliarity with the hazardous properties of certain ornamentals. Usually these cases do not involve the actual ingestion of plant parts. Rather, the inhalation of toxic smoke from certain yard trash and skin irritations from contact with plant sap are frequently seen. Cases of this type are rarely referred to the toxicology laboratory since the causative agents are generally identifiable by the patient, and the physical effects are mild, localized, and short-lived.

The second group constitutes the majority of cases presented to the laboratory for analysis and involves the ingestion of poisonous plants for reasons of curiosity. Incidents of this type involving adults are not unknown, but the majority of victims are small children whose fascination with berries and flowers of all types becomes a potential hazard, and are, in fact, eaten with frightening frequency. In cases of internal poisoning, children are likely to be more seriously affected than adults since the toxicity of a given dose varies inversely with body weight.

The third and most rapidly growing group of plant-induced poisonings includes those cases where toxic or poisonous plants are intentionally ingested to achieve a desirable end effect. Consciousness-altering substances, the hallucinogens, are found in this category. This phenomenon is generally limited to the late teens and early twenties age group and constitutes a real and growing problem for the hospital emergency room and the toxicology laboratory.

Before any analysis of patient samples for possible plant-induced poisonings can be initiated, certain general information is essential. The toxicologist must be familiar with the plants in the area most likely to cause poisoning. In Florida, the Division of Health, Florida Department of Health and Rehabilitative Services, published an informative pictorial booklet which describes the most common species, entitled "Florida's Poisonous Plants." The usual habitat, nature and severity of poisoning are included. The Agricultural Extension Service at the University of Florida in Gainesville also has literature available. One of the most useful is a pamphlet available free to Florida residents, "Poisonous Plants Around the Home," by Erdman West. The library of the toxicology laboratory should include references of this type if analysis of patient specimens in plant poisoning cases is to be attempted.

Once a list of the locally occurring poisonous plants is compiled, information on specific species documented as being responsible in poisoning cases may be obtained from the National Clearinghouse of Poison Control Centers, Food and Drug Administration, 5600 Fishers Lane, Rockville, Maryland 20852.

Samples of leaves, flowers, and berries from these plants can then be collected and used in the toxicology laboratory to create a "library" for later comparison of known poisonous plants with material isolated in cases of suspected poisonings. The use of such material as standards in the various methods of analysis is essential if positive identification of the causative agent is to be made. Exact chemical composition of many of the toxins in poisonous plants is as yet unknown, hence, in most cases commercially available pure standards cannot be employed.

For each suspected poisoning case, a complete

and accurate patient history must be obtained. This information is of paramount importance. At this institution a detailed form accompanies all requests for toxicological analysis (Fig. 1), plant-induced poisonings as well as others. Since symptoms of plant poisoning cannot be readily distinguished from disease states, and methods of analysis of specimens for plant poisons can differ from those used in other types of poisonings, the data presented on this information sheet provide the laboratory with important clues as to where to concentrate its initial efforts.

Without the cooperation of the emergency room staff or the attending physician in giving the laboratory complete and accurate information, chances of ever detecting causative agents in plant poisoning cases are greatly diminished and the time from specimen receipt to final report is correspondingly increased.

The optimum patient specimen depends upon several variables: plant species involved, amount of material ingested, and the length of time since ingestion. The gastric contents and urine are collected immediately upon presentation of the patient to the emergency room since these are the specimens most likely to yield satisfactory results.

The technique used to isolate the plant poisons will be dictated by the patient specimens obtained. If urine is analyzed, small amounts of the unchanged material may be excreted, but the majority will be chemically altered by the body to yield metabolites. The number and chemical relationship of these metabolites to the parent compound will vary with each species of plant. It should be remembered also that the amount of substance initially ingested is usually in milligram quantities, and only minute amounts of the metabolites will be excreted in any given time period. In most cases, the gastric content is the specimen of choice unless the length of time since ingestion is excessive. The concentration of the material will be the greatest in this specimen. In addition, there is a good possibility of isolating physically discrete pieces of the responsible plant. These can then be compared both chemically and physically to the established standards. Beware of the fact that Ipecac® is often used in conjunction with gastric lavage. The interference of this material with certain of the analyses can be overcome if the toxicologist is aware of its presence.

Direct analysis methods which eliminate time-consuming sample pretreatment and isolation are the quickest, but these have the disadvantage in that they are only applicable where gastric contents which contain pieces of the actual plant material are available. Hard berries, nuts, and even the leaves and stems of some plants remain intact in the stomach for extended periods of time and allow for visual inspection. Upon receipt of specimens in plant poisoning cases, the gastric contents should be immediately strained to isolate possible fragments of plant material. The Rosary Pea **(Abrus precatorius)**, for example, is a plant attributable to numerous poisonings and several deaths and can be tentatively identified by inspection. Provisional identification can be made quickly by this visual method provided the ingested material is at least partially intact and has distinctive identifying features.

Direct analysis of pieces of leaves and plant not immediately identifiable by sight can sometimes be accomplished by other means. A direct method utilizing an ultraviolet recording spectrophotometer has been invaluable in this laboratory for the rapid identification of the psilocybin-containing mushroom, **Psilocybe mexicana**. Suspected material is extracted with a suitable solvent (usually methyl alcohol), and the supernatant is scanned between 200 and 360 nanometers in order to reveal the absorbance pattern. Pictured in Fig. 2 A & B is the UV pattern of the entire **Psilocybe mexicana** mushroom as compared to that of the pure psilocybin standard. Edible mushrooms may be found in gastric specimens, but they will not display the characteristic peaks of psilocybin. Thin-layer chromatography, gas-liquid chromatography, as well as more sophisticated analytical methods can also be used in the direct analysis of suspect material; but ideally these require a more rigorous sample "clean-up" to be of value.

If, in the analysis of specimens in suspected plant poisoning, the direct approach is not possible (e.g., specimen of blood or urine or gastric content with no particulate matter), a more time-consuming extraction and isolation procedure must be employed. Numerous extraction schemes have been proposed. In this laboratory, large amounts of the specimen are extracted with a 96:4 mixture of chloroform/isopropanol at both an acid and a basic

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TOXICOLOGY INFORMATION SHEET

DATE:_____

This information sheet must be completed and forwarded to the laboratory accompanying all specimens for toxicological analysis. Please be as complete as possible. Accurate information saves hours of analysis.

PATIENT'S NAME: _____ HOSPITAL #:_____

Age: _____ Sex: _____ Race: _____ Occupation: _____

1. Toxicology is being ordered because: _____

   _____

2. What circumstances caused this patient to be brought to you? _____

   _____

3. Was patient in possession of drugs or drug-related materials? YES ☐ NO ☐

   If yes, explain: _____

4. Does patient have access to any drugs prescribed or belonging to someone else? YES ☐ NO ☐

   If yes, explain: _____

5. Does patient have a history of drug abuse? YES ☐ NO ☐ _____

6. Is the patient currently taking any medications? If so, what? _____

7. Do you suspect a particular substance as being the causative agent? If so, what? _____

   _____

8. What medications, if any, have you given the patient and what time were these given?

   Medication: _____ Time given: _____

   _____ _____

   _____ _____

9. Does the patient have needle marks? YES ☐ NO ☐ If yes, where are they and how fresh do they appear? _____

10. Does the patient have an unusual breath odor? YES ☐ NO ☐ If yes, explain: _____

    _____

11. Suspected route of administration: ORAL INJECTED INHALED OTHER: _____

12. Patient's physical condition on admission (circle):

    A. ALERT DEPRESSED SEDATED COMATOSE

    B. RATIONAL IRRATIONAL HALLUCINATING

    C. PUPILS DILATED PUPILS CONSTRICTED

13. Specimens necessary for Toxicological Analysis. PLEASE RECORD TIME SPECIMENS WERE COLLECTED.

    A. Whole Blood, Time Collected: _____

    B. Urine, Time Collected: _____

    C. Gastric Contents, Time Collected: _____
    (NOTE: If Ipecac has been used please send gastric anyway, but label the specimen container "Ipecac Used" since Ipecac will interfere with certain analyses.)

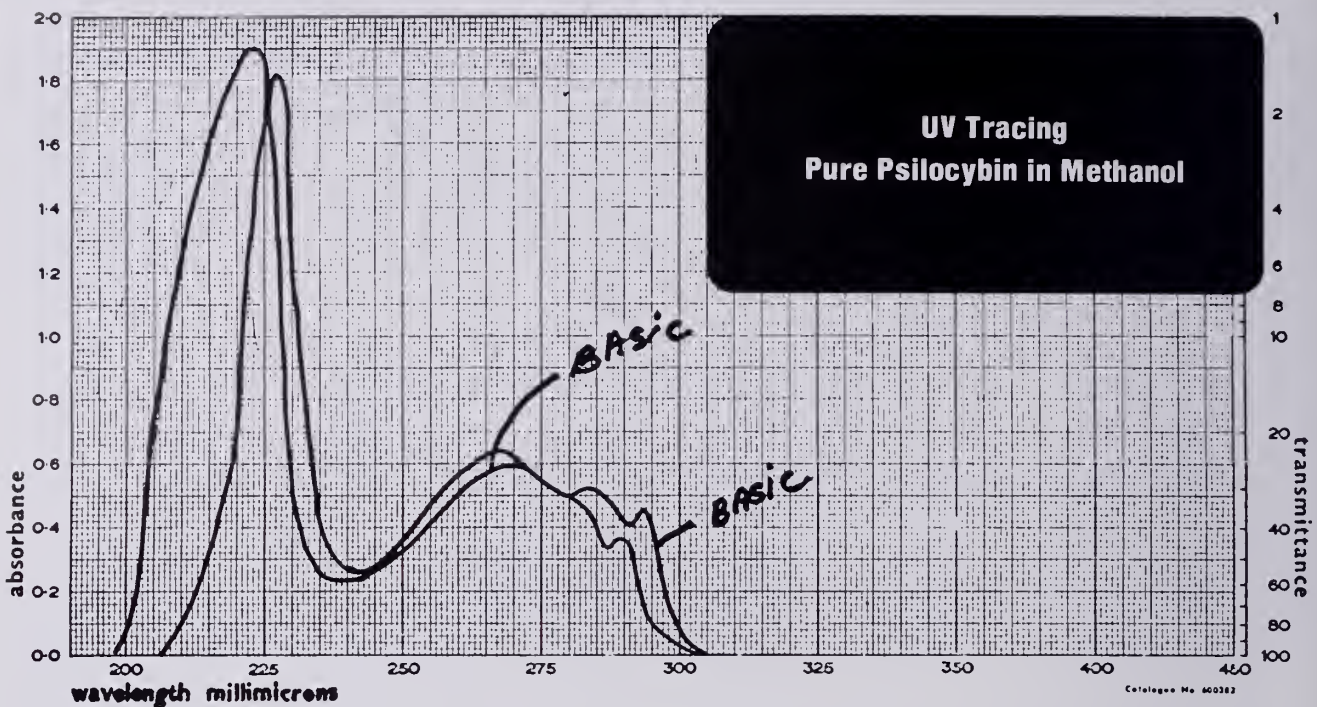
*** Also send to the Toxicology Dept. any medications, drugs, fluids, etc., that are in the possession of the patient.

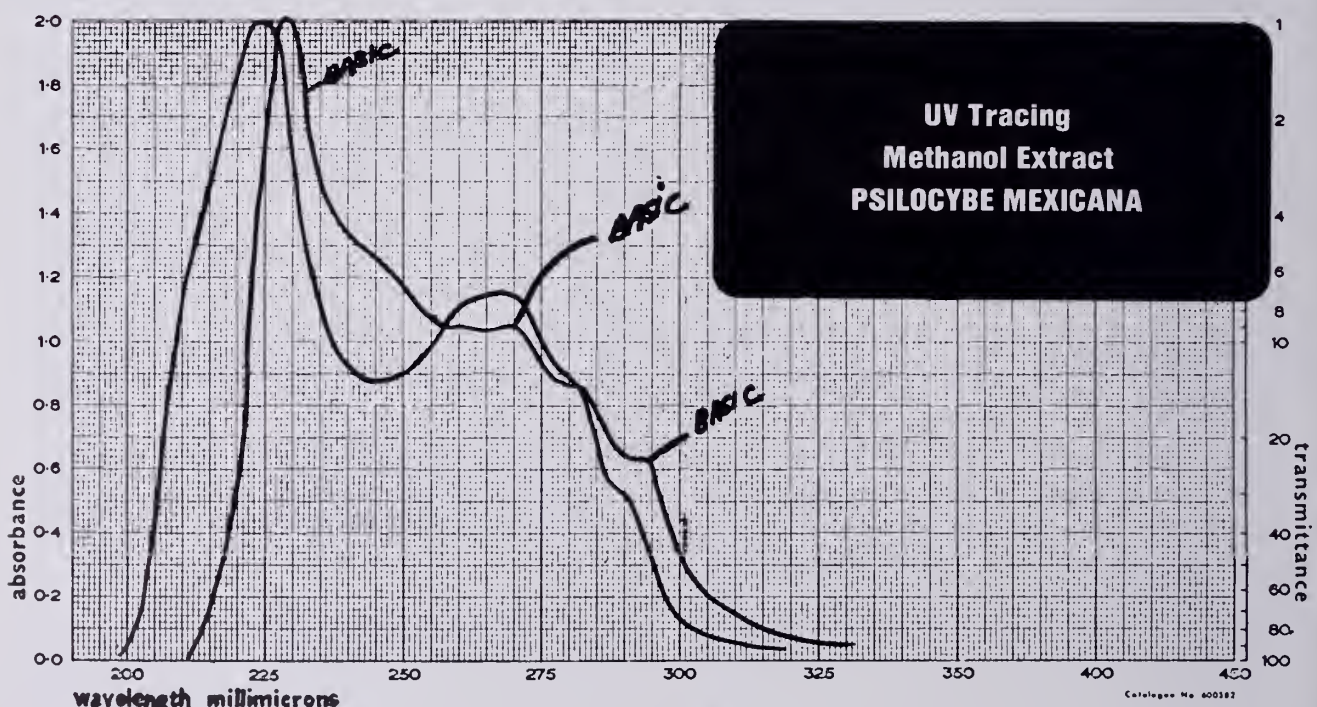
14. Will this patient be admitted to the floor? YES ☐ NO ☐ If yes, what room? _____

_____
Signature of person preparing this form

BH 13-2

Figure 1


UV Tracing
Pure Psilocybin in Methanol
BASIC
BASIC
absorbance
transmittance
wavelength millimicrons
2·0
1·8
1·6
1·4
1·2
1·0
0·8
0·6
0·4
0·2
0·0
1
2
4
6
8
10
20
40
60
80
100
200
225
250
275
300
325
350
400
450


UV Tracing
Methanol Extract
PSILOCYBE MEXICANA
BASIC
BASIC
BASIC
absorbance
transmittance
wavelength millimicrons
2·0
1·8
1·6
1·4
1·2
1·0
0·8
0·6
0·4
0·2
0·0
1
2
4
6
8
10
20
40
60
80
100
200
225
250
275
300
325
350
400
450

Figures 2A & B

pH. The organic phase is taken to dryness and the remaining residue is used in various methods of analysis. It is this more involved extraction procedure which must, most often, be employed.

Once the material has been isolated, the methods which can be used to accomplish identification are legion. The particular procedure used will depend on such factors as specimen type and quantity, available time, laboratory instrumentation, test cost, and laboratory expertise.

An inexpensive but useful analytical technique is that of thin-layer chromatography. The use of TLC for the separation and identification of compounds in poisonous plants is popular because of great speed, sensitivity, and high resolution. Expensive ancillary equipment is not necessary and technicians can be adept at the method with little training. Concentrated extracts from the available specimens are spotted on a chromatography plate along with known standards. The plate is placed in Davidow developing solvent (ethyl acetate: methanol: ammonia; 85: 10: 5), dried, and sprayed with location reagents. The characteristic color reactions and mobility (Rf) of the known standards and the components of the unknown specimens are compared.

Ultraviolet Absorption Spectrophotometry is another analytical tool used in the identification of compounds responsible for plant poisonings. The use of this UV method has already been discussed in the section on direct analysis, but it is equally useful after the extraction step. The identification of an unknown compound cannot be made on the basis of UV absorption spectrophotometry alone, but the pattern of the absorption of the unknown at various wave lengths can give the analyst valuable clues. A dual beam recording spectrophotometer is employed. The patterns of the absorbance of the unknown in the ultraviolet range can be recorded and compared to the tracings of known standards. Standard maps of common poisonous plants should be kept on file in the laboratory to facilitate identification. Changes in the pH of the solvent can demonstrate isobestic points, bathochromic and hypsochromic shifts; all of which help to identify the specific compound.

Gas-liquid chromatography is yet another technique which can be used to great advantage in the identification of poisonous plants which have been ingested. The retention times obtained are completely temperature and column dependent, but as with UV spectrophotometry and thin-layer chromatography, identification is made by comparing the unknown to a standard. For analyses of this type, a flame ionization detector is most commonly employed. The sensitivity of this detector reaches into the tenths of nanogram range—ideal for samples with only minute amounts of the compounds of interests. Gas chromatography requires more expensive equipment as well as more laboratory expertise, but a gas chromatograph is truly a necessity if analyses for plant poisonings are to be done routinely.

As knowledge of the subject of plant poisonings increases, more sophisticated equipment such as the Infra-red Spectrophotometer and the Mass Spectrometer, will likely be brought into use. These systems can detect and identify substances to the billionth of a gram. At the current time, however, the cost of such sophisticated equipment restricts these methods to the research laboratory. In the meantime, it is the responsibility of all toxicology personnel to adapt the existing methods of detecting the causative agents in plant poisonings to their own laboratories.

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Role of State Health Department and Government in Dealing With Poisonous Plants

H. Preston Mathews, M.P.H.

Abstract: The principal role of the State Health Department in dealing with the problem of poisonous plants is education of the people and transmission of information concerning the services performed. These services consist of data collection and interpretation, epidemiological investigations, laboratory support systems, regulation of hazardous products, and rendering direct services to the individual.

Government, through its various departments, has an obligation to its constituency in matters concerning poisonous plants much as it does in other potentially dangerous situations. Analysis of the various state, federal, or local agencies provides one unilateral function that most agencies are involved in — education/information. Often governmental agencies are thought of for their regulatory powers but due to the widespread native and cultivated growth of toxic plants in Florida their specific regulation and control is virtually impossible. Therefore, education efforts are usually directed toward the general public or to a specific target audience in an effort to provide recognition of poisonous plants or to indicate acceptable first aid procedures. Some examples are: the Florida Department of Agriculture and Consumer Services provides information on poisonous plants in general as well as materials developed for home owners and gardeners with recommendations for landscaping and decorating with plants indicating commonly used plants which are poisonous; federal and state game and wildlife agencies often provide materials prepared specifically for outdoorsmen; various other agencies (Department of Transportation, Departments of Park and Recreation often provide more direct warning in situations where plants may present an immediate hazard such as signs cautioning against the burning of oleanders or using them as cooking skewers. True, these efforts are often limiting and many individuals feel that more direct control over potentially hazardous plants are in order. However, this problem is very similar to many other situations and the individual needs to be informed in order to assume a more direct responsibility for his own well being.

Florida's public health agency, the Department of Health and Rehabilitative Services (DHRS), in its concern with wellness of individuals and how this determines total community wellness has a role in dealing with poisonous plants. Like other agencies the most apparent is through the educational/informational media. However, there are aspects of a public health agency's role that are not usually evident. Some of these services which go relatively unnoticed are data collection and interpretation, epidemiological investigations, laboratory support services, regulation of hazardous products, and rendering of direct services to individuals

Many individuals are familiar with mortality data used as indices of health problems, and it is likely that much of the data cited in previous articles was obtained through DHRS's Vital Statistics Office. While mortality data is usually among the first to be cited, morbidity data and its availability is usually lacking. Through the Health Program Office, DHRS is working to establish a disease surveillance and data flow system which will provide relevant statistical data for determining the scope of specialized health problems.

Epidemiological expertise is available through the DHRS Health Program Office. This service proved beneficial in 1966 by tracking down a fresh water related poisoning problem. In this instance a county health department received complaints about a number of dogs dying in the vicinity of a lake which was emitting an odor. Considerable concern for the health and welfare of the residents in the area was rapidly developing since some of the children had been reported with gastrointestinal illnesses. When bacteriological analysis proved futile, further laboratory and epidemiological support defined the problem as apparent blue-green algae (**Microcystis aeruginosa**) poisoning. This situation was likely due to a bloom that occurred and then subsided in this

particular lake. A similar example of epidemiological support services is noted in association with the occurrence of the bloom creating the highly publicized "Red Tides" that occur along Florida's coast.

Specialists in environmental health are commonly identified with their functions involving the inspections of restaurants, water supply, sewage disposal, nuisance investigations, and the like, and few people realize that these health workers often have a responsibility in enforcing the Hazardous Products Act. While regulation of specific poisonous plants is not a reality, there are regulations regarding their use in various products. Such an example is the case where the rosary pea was being used as "love beads" and presented a particularly hazardous situation to children and adolescents. In that situation, county health department sanitarians played an important role in seeing that the product was removed from the market. Also these specialists are often the first to be called by citizens if it is believed that a certain existing condition is unsafe or a nuisance.

Another service provided primarily through county health departments in dealing with poisonous plants is centered on the various clinical and nursing programs. As a result of the availability of poison control centers throughout Florida, direct services provided by county health departments are not as likely to be needed as they once were in treating poisoning cases. However, public health nurses are still likely to observe dermatological symptoms of plant poisoning in clinical situations or they may observe the presence of poisonous plants in a home where a toddler may be at risk. Under these situations, clinical and educational services are again in order for treatment and as a preventive measure.

These are but a few examples of the varying roles that governmental agencies and, in particular, the public health agency might have in dealing with poisonous plants. By identifying the roles in Florida's situations many other related and similar needs have been detected, and are being addressed by the Health Program Office of the Department of Health and Rehabilitative Services.

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Summary by Guest Editors

The intent of this Florida Medical Journal is not to perpetrate a scare tactic. The purpose is educational, to inform medical personnel and those interested in the medical aspects of adverse reactions from plant life that can occur to people, especially children. In this issue primarily the plants encountered in Florida are discussed, although other states have similar problems. They are universal, existing wherever there is life in any form because nature gives each living thing a "survival kit" to protect itself, thus allowing it to survive and procreate.

In protecting themselves, plants cause injury by mechanical means, poisons, allergic sensitization, appearance, odor, and probably other means. The injury may be psychological such as fear or physical.

Recognition of potentially harmful plants is the most important factor in avoiding harm. Do not touch that which you do not know. Learn the plants in your home and yard and in your neighbor's yard. Know what is in the parks where your children play. To protect yourself and your family enter these facts into a compartment known as "knowledge" and allow your intelligence to react to protect you and yours from injury from plants which are trying to protect themselves. Description of the plants with photographs is helpful. An excellent book is Julia Morton's "Plants Poisonous to People in Florida."

The mechanisms of injury to people have been discussed. A few resumes are given.

It is not necessary to touch plants to be injured; one can contact pollen, plant parts, and oils by other means. Poison ivy can be contacted in the air, especially if being burned, and from animal hair. Algae material can be contacted in water and pollen anywhere it falls.

Certain plants produce an irritant material that causes lesions in all people who contact it in high enough doses. These products act both as irritants and sensitizers. Other plants produce a sensitizing substance that causes more than one system to react. Ragweed can produce hayfever, asthma and allergic dermatologic lesions. Two different antigens are found in its pollen, an aqueous extract and an oleoresin factor. Thus, similar lesions may be found from different plants. This can account for differences in diagnoses.

Injuries may be caused by thorns, burrs, spines, and awns. Some also are poisonous. These are treated frequently by surgical means but may only require adhesive material to remove smaller awns, especially if there are many. Depilitating materials are often used but are seldom of complete usefulness.

Some general rules for prevention of injuries produced by plants are:

1. Know your plants; if you do not know, find out. This is important because of the flowers and plants growing in your vicinity.

2. Do not eat or handle any plant or flower of which you know nothing. Do not eat mushrooms unless they are commercially sold. Let professionals make positive identification.

3. If there are infants and children in the home, do not have poisonous plants or those which may cause injury. Mechanical injury such as to the eye is as disrupting as severe poisoning and leaves a feeling that your responsibility was not maintained.

4. Bulbs should be stored so that the susceptible child cannot reach them nor open the container. This is also true for chemicals used for growing plants.

The greatest cause of death and disability from plants arises from their misuse to produce materials that are toxic, carcinogenic, narcotic, and psychodelic. Death and disability result from misuse of tobacco, alcohol which is derived mainly from cereals and other plants, and narcotics and psychodelic drugs which frequently are poisonous as well. It is well known that tobacco is a carcinogen that has taken thousands of lives by production of cancer of the lung. Chewing tobacco has not been found harmless. It must be surmised that rats have not as yet been affected since the tobacco package has only a note stating that smoking is harmful. No real effort has been made to control the manufacture, marketing, or use of this material, nor has there been any attempt to provide a harmless, nonlethal substitute.

Alcohol, a man-made distillate of prebiblical use and tolerance, has produced a disease often ending in death called alcoholism. The fact that these individuals kill themselves should not be considered unimportant. Their propensity to kill or maim others by the misjudgment produced by use of alcohol is well known. Of the thousands killed yearly many are not the drunken individuals blamed for the killing.

The psychodelic effects of narcotics and other drugs, plants, and plant parts are still with us. These substances are marketed more or less illegally but with attempts to tolerate these killing and maiming drugs.

Plants should not be considered the perpetrators of poisoning. Plants are manipulated by the intelligence, or should we say the greed, of humans to produce harm and death among the populace who, because of their apathy, allow the growth of tolerance to the use of dangerous drugs.

Philip Blank, M.D.
Laudie E. McHenry, M.D.

Appendix I

Quick Reference Section

Plants, Symptoms and Treatment

This section is designed for quick reference. The primary classification is according to symptoms induced by poisonous plants, together with brief comments on initial treatment, and also with a listing of plants most likely to cause such symptoms. We hope that this brief outline may be helpful as a nucleus in preparing a reference chart or folio for initial treatment.—Editors.

Plants may produce adverse reactions in many ways. A plant may have several methods. For example, a single plant may cause GI symptoms, have atropine effects, and irritant effects. Various parts of plants may offend in various ways, the sap, leaves, fruit or roots may contain the same material or different chemicals that may cause several reactions. Treatment and symptoms may be varied and bizarre under certain conditions and thus cause difficulty in diagnosis of lesions. A curious individual many encounter more than one type of plant, all of which may be toxic. Emergency treatment should be evacuation of stomach contents, preferably by induction of emesis, and supportive care. When laboratory analyses or physical findings are specific, selective treatment should be initiated.

Following is a brief description of symptoms of most reactions, with a short treatment summary. This discussion is not intended to replace comprehensive reference material but simply to suggest the beginning of emergency therapy. It is suggested that a folio be made up to answer the questions of diagnosis and therapeusis in every office or clinic or station where these problems are apt to present themselves. The main object of this paper is to awaken the interest of people who must meet these problems.

The plants listed are those most commonly known to cause these symptoms, at this time. Undoubtedly, there will be additions to these lists as other plants are proven to be toxic.

OUTLINE OF SYMPTOMS DUE TO ADVERSE REACTIONS TO PLANTS

I. Plants causing gastrointestinal symptoms.
II. Plants having digitalis-like actions.
III. Plants producing acute poisoning symptomatology, with collapse.
IV. Plants having narcotic atropine-like action.
V. Plants producing convulsions.
VI. Mushrooms.
VII. Plants producing dermatitis, irritative and allergic.
VIII. Plants producing photodermatitis.
IX. Plants affecting central nervous system, with symptomatology ranging from hallucinogenic to coma and respiratory arrest.
X. Plants producing primarily respiratory symptomatology.

I. Plants causing gastrointestinal symptoms.

Symptoms

Practically every toxic material taken by mouth can or may cause GI symptoms but may produce more than oral irritation, and may cause emesis, abdominal pain and diarrhea of various degree, with dehydration and electrolyte imbalance. This dehydration and electrolyte imbalance may result in severe danger especially to children. Urgent care is indicated.

Treatment

Unless profuse spontaneous vomiting has occurred, treatment consists of inducing emesis by ipecac followed by giving or instilling a slush of activated charcoal. Watch for dehydration and electrolyte imbalance. Attempts to find the cause of the GI disorder should be made, especially for the more severe intoxications, since some contain toxins which are potentially life threatening.

Plants

The common names of some gastroenteritis-producing plants are listed: Rosary Pea, Coral Plant, Physic Plant, Bellyache Plant, Castor Bean, Philodendron, Dumb Cane, Poke Weed, Sandbox tree, Lumbang Nut, Balsam Pear, Mast Wood, Mushrooms, Akee, Coonite, False Sago Palm, Spurge Laurel, Daphane and Buttercup, Yellow Allamanda, Mistletoe, Chinese Wisteria, Crinum Lily, Pokeweed, Caladiums. (The botanical names can be found in the illustration index and in various articles in this edition). The specific toxins found in this group of plants are: lycorine, taxine, protoanemonin,

resin, saponin, toxalbumin, oxalate. (See separate article on Rosary Pea poisoning, this issue).

II. Plants having digitalis-like actions.

Symptoms

Cardiac conductive disorders which may be associated with diarrhea and abdominal pain due to the presence of saponins and other irritants.

Treatment

Based on ECG findings. First degree block, no treatment needed. More advanced block, IV atropine (consult cardiologist as soon as possible). Disturbances of automaticity in the absence of conductive defects may be treated by potassium chloride. Serious disturbances of rhythm may be relieved by potassium chloride in 5% glucose in water. Serious involvement of the conductivity system in conjunction with serious rhythm disturbances should have a slow IV drip of 50 to 100 mg of diphenylhydantoin at intervals until the arrhythmia is suppressed and then followed by oral administration of diphenylhydantoin according to the cardiologist. This treatment is not meant to over-ride a cardiologist's treatment but rather to give some therapeusis until he is able to supervise the situation.

Plants

Oleander (Nerium oleander), Lucky Nut (Thevetia peruviana), Lily of the Valley (Convallaria majalis). Foxglove (Digitalis purpurea), Rubber vine (cryptostegia grandiflora), Devil's Apple, Love Apple.

III. Plants producing acute poisoning symptomatology with collapse.

Symptoms

Usually a spontaneous emesis within one hour or less after ingestion. Profuse salivation, confusion, headache, incoordination, hyperpyrexia and occasional mydriasis and tachycardia may be produced. Fatality is from respiratory failure.

Treatment

Alkaloids are effectively absorbed by charcoal; assist respiration.

Plants

Wild Tobacco Leaves (Nicotinana spp) contains nicotine. Golden Chain Tree (Laburnum anagyroides) contains cystine. Poison Hemlock (Conium maculation), contains coniine.

IV. Plants having narcotic atropine-like action.

Symptoms

Blurring of vision, dryness of mouth, dysphagia, skin hot, dry, and flushed, and rash about ears, face and neck. Hyperpyrexia, hallucinations, delirium, coma and death. Convulsions in children.

Treatment

Slow administration of physostigmine until symptoms abate.

Plants

Angel's Trumpet (Datura candida), Jimsonweed (Datura stramonium), Chalice Vine (Solandria nitida), Day Jessamine (Cestrum diurnum), and Devil's Trumpet (Datura metel).

(See separate article on Angel's Trumpet poisoning, this issue).

V. Plants producing convulsions.

Symptoms

Nausea, salivation, grand mal seizures. Death secondary to prolonged anoxia during tonic contractures.

Treatment

Is the same as for status epilepticus.

Plants

Water Hemlock (Circuta spp.) and Golden dewdrop.

VI. Mushrooms.

Symptoms

Irritative or idiosyncrasy: Abdominal pain, nausea or diarrhea. May be psychomatic, usually revealed by history but no chances should be taken. Toxic: Nausea, abdominal cramps, severe gastroenteritis, vomiting and diarrhea. Oliguria may occur. Hallucinogenic: Feeling of well being with dizziness and weakness. Visual disturbances and hallucinations. Sleep followed by elation to manic excitement.

Treatment

Control of dehydration and electrolyte imbalance due to vomiting and/or diarrhea. Activated charcoal for absorption of some toxins. Primarily treatment is aggressive symptomatic care with maintenance of hydration and electrolyte balance and blood glucose. Specific therapy may be needed. Autonomic nerve system may be involved.

Specific plants not listed due to complexity of this subject. (See separate article on mushrooms, this issue.)

VII. Plants producing dermatitis, irritative and allergic.

Symptoms

Irritative lesions: Pain or burning eczematoid dermatitis which may have weeping, erythema, and tissue damage. May be secondarily infected. Allergic lesions: Erythematous lesions with vesiculation frequently linear with marked itching. Urticarial lesions alone or in combination with eczematous lesions.

Treatment

Removal of irritant or allergen with soap and water and the use of soaks or mild lotions. It is more important to keep medications away from the lesions than simply applying medicants that may act as irritants or allergens and further irritate the lesions and produce prolonged severe effects.

Plants

Many irritants and allergens may be demonstrated in plants known to cause dermatitis in most cases but they can also be demonstrated in plants that seldom cause dermatitis in humans. The dermatitis depends not only on the plant but on the subject. Probably the plants that produce the most cases of allergic dermatitis are Poison Ivy and its family. Some plants produce both irritants and allergens. The common names of some of these plants are listed: Poison Ivy, Poison Oak, Poison Sumac, Chili Pepper, Fishtail Palm, Tread Softly, Red Spurge, Candelabra Cactus, Pencil Tree, Poinsettia, Manchineel, Oyster Plant, Purple Queen, Aralia, Century Plant, Elephant's Ear, Dumb Cane, Hunter's Robe, Lime and Poison Wood, Slipper-Flower, Cashew Nut, Mexican Flame Vine and Moonflower. (See separate article on plant allergy and sensitivity, this issue).

VIII. Plants producing photodermatitis.

Symptoms

Dermatitis, eczematoid with or without vesiculation and pigmentation following exposure of skin to chemical through which light rays have penetrated.

Treatment

Stay out of direct sun rays. Use of skin protectors such as clothes, creams, lotions and ointments substances that prevent the passage of sunlight.

Plants

Plants that produce furocoumarins. (See article on this topic, this issue). Examples are Wild Parsnip (Pastinaca sativa), Gas Plant (Dictamnus albus), and Lantana (Lantana Camara).

IX. Plants affecting central nervous system, with various symptomatology including coma and respiratory arrest.

Symptoms

May act as a hallucinogen, producing mood changes, various hallucinations and may lead to coma and finally death. There may be nerve damage with numbness, sensitivity to light, paralysis frequently affecting muscles causing weakness of limbs, and terminally respiratory arrest. Convulsions may or may not occur.

Treatment

The use of charcoal which tends to absorb the toxins, and supportive car Plants: Carolina Jessamine (Gelsemium sempervirens), Pokeweed (Phytolacca americana), Lantana (Lantana camara), Chinaberry (Meli azedarach), Glory Lily (Gloriosa rothschildiana), Black Nightshade (Solanum nigrum), Privet, and Coral Tree (Jatropha species).

(See also section on plants causing narcotic atropine-like symptoms).

X. Plants producing primarily respiratory symptomatology.

Symptoms

Asthma, hay fever, allergic rhinitis, conjunctivitis, dyspnea, cough (allergic). Irritative (non-allergic) chronic bronchitis, bronchiolitis, farmer's lung, irritative rhinitis; dyspnea and cough without wheezing.

Treatment

Allergic workup for allergic cases; for emergency use adrenalin, antihistaminics and steroids.

Plants

All trees and plants producing antigenic pollen such as those producing airborne pollen containing antigens of grasses; certain weeds such as ragweed, chenopods and amaranths, also molds, dusts from plants and nonplants. A few examples are Night-Blooming Jessamine (Cestrum nocturnum), False Sago Palm (Cycas circinalis), Angel's Trumpet (Datura candida), Chalice Vine (Solandra nitida), Castor Bean (Ricinus communis), Garlic Vine, and Vitex species. (See separate article on plant allergy and sensitivity, this issue).

Appendix II

Poison Control Centers of Florida*

Apalachicola
George E. Weems Memorial Hospital, P. O. Box 610, Franklin Square, 32320, (904) 653-3311.

Bartow
Polk General Hospital, 2010 E. Georgia St., P. O. Box 81, 33830, (813) 533-1111, Ext. 237.

Bradenton
Manatee Memorial Hospital, 206 2nd St. E., 33505, (813) 746-5111, Ext. 466.

Daytona Beach
Halifax District Hospital, Clyde Morris Blvd., P.O. Box 1990, 32015, (904) 258-1611.

Fort Lauderdale
Broward General Hospital, 1600 S. Andrew Ave., 33316, (305) 525-5411, Ext. 513.

Fort Myers
Lee Memorial Hospital, 2776 Cleveland Ave., P. O. Drawer 2218, 33902, (813) 332-1111.

Fort Walton Beach
General Hospital of Fort Walton Beach, 1000 Mar-Walt Drive, 32548, (904) 242-1111, Ext. 106.

Gainesville
Alachua General Hospital, 912 S.W. 4th Ave., 32601, (904) 372-4321.

J. Hillis Miller Health Center, University of Florida, 32601, (904) 392-3261.

Jacksonville
St. Vincent's Hospital, Barrs St. & St. Johns Ave., 32204, (904) 389-7751, Ext. 315.

Key West
Florida Keys Memorial Hospital, P. O. Box 1359, 33040, (305) 294-5531.

Lakeland
Lakeland General Hospital, Lakeland Hills Blvd., P. O. Box 480, 33801, (813) 683-0411.

Leesburg
Leesburg General Hospital, 600 E. Dixie, 32748, (904) 787-7222, Ext. 221.

Melbourne
Brevard Hospital, 1350 Hickory St., 32901, (305) 727-7000, Ext. 765.

Miami
Jackson Memorial Hospital, 1700 N.W. 10th Ave., 33136, (305) 325-7429.

Miami Beach
Mt. Sinai Hospital of Greater Miami, 4300 Alton Rd., 33140, (305) 674-2121 or 674-2200.

Naples
Naples Community Hosptial, 350 7th St. N., 33940, (813) 262-3131.

Ocala
Munroe Memorial Hospital, 1410 S.E. Orange St., 32670, (904) 732-1111, Ext. 15.

Orlando
Orange Memorial Hospital, 1416 S. Orange Ave., 32806, (305) 841-8411, Ext. 656.

Panama City
Memorial Hospital of Bay County, 600 N. MacArthur Ave., 32401, (904) 769-1511.

Pensacola
Baptist Hospital, 1000 W. Moreno St., 32501, (904) 434-4011, Ext. 4811.

Plant City
South Florida Baptist Hospital, Drawer H, 33566, (813) 752-1188.

Pompano
North Broward Hospital, 201 Sample Rd., 33064, (305) 941-8300, Ext. 710.

Punta Gorda
Medical Center, 809 E. Marion Ave., P.O. Box 1507, 33950, (813) 639-3131, Ext. 129.

Rockledge
Wuestoff Memorial Hospital, 110 Longwood Ave., 32955, (305) 636-2211, Ext. 506.

St. Petersburg
Bayfront Medical Center, Inc., 701 6th St. S., P.O. Box 1438, 33701, (813) 894-1161, Ext. 242.

Sarasota
Memorial Hospital, 1901 Arlington Ave., 33579, (813) 955-1111, Ext. 1241.

Tallahassee
Tallahassee Memorial Hospital, Magnolia Dr. and Miccosukee Rd., 32303, (904) 599-5100.

Tampa
Tampa General Hospital, Davis Islands, 33606, (813) 253-0711.

Titusville
Jess Parrish Memorial Hospital, 951 N. Washington Ave., 32780, (305) 269-1100, Ext. 474.

West Palm Beach
Good Samaritan Hospital, 1300 N. Dixie Hwy., 33402, (305) 655-5511, Ext. 341.

Winter Haven
Winter Haven Hospital, Inc., 200 Avenue F, N.E., 33880, (813) 293-1121, Ext. 222.

* From National Clearinghouse of Poison Control Centers, Department of Health, Education, and Welfare, July 1976.

Appendix III

Recommended Reference Books and Articles

The Editors believe that the following list of references and articles are probably the most useful materials for poisonous plants. Those references indicated by an asterisk are especially recommended for emergency rooms, offices, and clinics where poisonous plants or their effects may be encountered.

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Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Major Medicinal Plants: Botany, Culture and Uses by Julia F. Morton, D.Sc. 431 Pages. Price $49.50. Charles C. Thomas, Publisher, Springfield, Illinois, 1977.

Probably the only current reference of its kind, this book describes the principal plants which have played an important medicinal role throughout modern history and many of which still furnish the active ingredients for numerous prescription therapeutic drugs, as well as over-the-counter medications. The book is sectioned along botanical lines, with the plants discussed arranged in family order and alphabetically by genus. Discussion in each section is subdivided into the following topics: Origin; geographic distribution; areas of cultivation; yields; chemical constituents; economic uses; toxicity, if applicable. The botanical features, culture, harvesting, and handling of medicinal plants is described in unprecedented depth. The text emphasizes technological advances which affect the feasibility of the crops, availability of supply, quality of products, etc. The material explains new uses for old drugs, as well as their old uses which still persist, also uses which have long since been discontinued. New plant sources of drugs are explored, many of which have given rise to new industries, or which have been developed as by-products of established industries. All of the plants discussed are illustrated, either with photographs taken by the author, or by reproductions of classic plates. Unfortunately, most of the illustrations are in black and white, but seem to be clear and concise in their illustrative material.

The text is written in an authoritative, readable style. Of particular interest, and affording considerable pleasurable informative reading, are the sections concerning the extraction of steroids from Mexican yams (Agava sisalana), and the section on the Opium Poppy (Papaver somniferum).

According to the author, this book is an effort to bring together a concise accurate accounting of the physicial aspects of each of the major medicinal plants currently in use, with brief outline of chemical constituents, as well as an indication of past and present therapeutic uses. The author states that the book is not meant to be a textbook in pharmacognosy, but in the opinion of this reviewer, this will be a valuable reference text for any student of that science and this work bridges sometimes rather wide gaps of information between technology, industrial aspects of botany, horticulture, pharmacology, and therapeutic medicine. This text will be an important reference for students and interested persons in any of the previously mentioned fields.

The index of the book appears quite thorough, using not only botanical terms, but also chemical and medicinal terminology. The appendix of the book includes two useful tables, one showing "Medicinal Plants no longer Official in the United States, but still mentioned in the U. S. dispensatory or American textbooks on Pharmacognosy, and sometimes still in use abroad," and a second table which shows useful information on "Plants which serve as pharmaceutical aides or adjuncts." Hence, this text has not only useful current information on the subject of Materia Medica, but also offers important historical data.

The author, Julia Morton, Director of the Morton Collectanea, University of Miami, Coral Gables, Florida, is one of the nation's recognized authorities in the botanical aspects of medicinal and toxic plants. Her numerous publications which include charts and texts are in use throughout Florida and the nation in medical clinics, and hospital emergency rooms.

(NOTE: It is indeed a pleasure for me to have had the opportunity to review the above text by Julia Morton, a major contributor to this special issue of the Journal of the Florida Medical Association. In other parts of this issue, there are references to other works of Julia Morton, as well as the contribution of a major article by her. Most of the plant illustrations in this issue have been graciously supplied by Julia Morton. — Ed.)

L. E. McHenry, M.D.
Melbourne

Dr. McHenry is one of the Guest Editors for this issue of the Journal, and a practicing Pathologist in Melbourne.

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EDITORIAL

National Immunization Initiative

The U. S. Department of Health, Education and Welfare announced an intensive effort to stimulate national improvement of immunization levels beginning in 1977. The effort, termed "Immunization Initiative," appropriated project grant funds for states to use to improve current immunization levels. The Initiative also gives priority to establishing systems to maintain good immunization levels in the future.

In Florida, the joint efforts of private physicians and public health clinics have achieved good immunization levels in kindergarten and first grades. Major strides toward improving immunization levels in infants and pre-school children have also been made. A recent audit of kindergarten and first grade enterers indicated that more that 92% were immunized with required vaccines (DPT, OPV, MMR).

A 1977 survey of the immunization status of two year olds shows that 61% were fully immunized.

Comparisons of completion percentages for children being immunized in private physicians' offices revealed that 83.5% were complete. Fewer (53.9%) of those being immunized in public health clinics were complete. A top priority during the Initiative in the public sector will be to identify the children who are not being completed on schedule and to direct follow-up efforts at them. It is felt that a similar effort in the private sector would also be beneficial.

Another important priority is the prompt identification and reporting of cases of vaccine preventable diseases. Evaluation of reported cases will permit Florida to determine areas where the potential for outbreaks exists and to introduce corrective measures. — E. Charlton Prather, M.D., Associate Editor.

Provision of Vaccine to Private Physicians

As part of the Immunization Initiative, private physicians, through their national organizations, are being encouraged to review the records of their patients to ensure adequate immunizations appropriate to age. More than 50% of children receive care, including immunizations, by private health care providers rather than by public agencies.

The provision of vaccine to private physicians by immunization grantees is urged under the following condition:

> Physicians who agree to a maximum charge of no more than $1.00 for the procedure and who agree to use the vaccine in accordance with Supplemental Guidelines for Immunization Project Grants dated December 20, 1977. The National Medical Association is currently considering this type of proposal for their 6,000 members.

Additionally, within budgetary constraints of the projects, physicians may be furnished vaccine purchased with project grant funds for vaccination in their office if they agree to make no charge to the patient for the vaccine even though they may charge for their professional services, providing they also use the vaccines in accordance with the Supplemental Guidelines.

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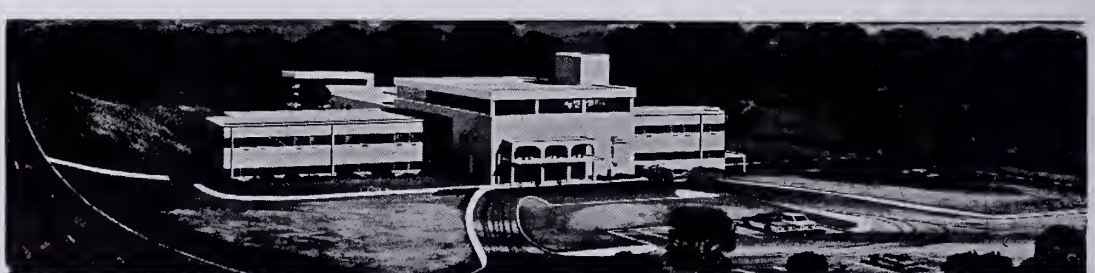
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MEETINGS

Approved by the FMA Committee on Continuing Medical Education

APRIL

New Concepts Toward Better Health Care, Apr. 1-2, Eden Roc Hotel, Miami Beach.*

1978 CME Sequential Review Courses, Apr. 1 — June 24 at 9:00 a.m. - 12:30 p.m. on Saturdays in Daytona and Tampa, and Sundays in St. Petersburg and Orlando from Apr. 1 — June 24 (excluding Memorial Day weekend May 27).

Treatment of Violence, and Violence in Our Society, Apr. 6, Kapok Tree Inn, Fort Lauderdale. For information: Ms. Peggy Jackson, 330 S.W. 27th Ave., Fort Lauderdale 33312.

Malignant Hyperthemia, Apr. 6-9, Miami.*

Medical Seminars — Gold Coast Seminar Center, Apr. 7-8, Good Samaritan Hospital, West Palm Beach. For information: Harold A. Yount, M.D., P.O. Box 3166, West Palm Beach 33402.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 10-15, Miami.*

Fifth Annual Scientific Session, Apr. 11-14, Hilton Hotel, Jacksonville. For information: Charles L. Gaudry Jr., M.D., Department of Family Practice, Naval Regional Medical Center, Jacksonville 32201.

Basic ECG for the Primary Physician, Apr. 13-16, Hyatt Regency Hotel, New Orleans. For information: Caral Sparks, EMSS, 3900 N.W. 79th Ave., Miami 33166.

Obstetric Anesthesia — Fourth Annual Seminar in Memory of Virginia Apgar, M.D., Apr. 14-16, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Sixth Annual Intensive Care Symposium, Apr. 15-17, Miami.*

Emergencies in Internal Medicine, Apr. 17-20, Miami.*

Advanced Electrocardiography and Arrhythmia Management for the Family Practitioner, Apr. 20-22, Gainesville Hilton, Gainesville.

Law and Emergency Medicine, Apr. 20-22, Key Biscayne Hotel, Key Biscayne, Miami. For information: Caral Sparks, EMSS, 3900 N.W. 79th Ave., Suite 469, Miami 33166.

Combined Ob-Gyn & Pediatric Seminars — Gold Coast Seminar Center, Apr. 21-22, Good Samaritan Hospital, West Palm Beach. Harold A. Yount, M.D., P.O. Box 3166, West Palm Beach 33402.

ENG (Electronystagmography) Seminar and Workshop, Apr. 28-29, Orlando.*

***For information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

MAY

Non-Invasive Diagnostic Techniques in Family Medicine — The Aging Patient, May 5, Miami Beach.+

Second Annual Symposium on Underwater Medicine, May 4-8, Miami.*

104th FMA Annual Meeting Scientific Program, May 3-6, Diplomat Hotel, Miami Beach. For information: Henry M. Yonge, M.D., P.O. Box 2411, Jacksonville 32203.

Seizure Disorders, May 5, VA Center, Bay Pines. For information: John C. Gallagher, M.D., Chairman, Education Committee, VA Center, Bay Pines 33504.

Newer Clinical Perspectives in the Management of Myocardial Infarction and Coronary Artery Disease, May 5-6, Barefoot Beach Inn/Sheraton Motor Inn, Panama City Beach. For information: Ernest G. Haslam, M.D., P.O. Box 491, Panama City 32401.

Oncology in Community Practice, May 8, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Boulevard., Inverness 32650.

Post-Convention Seminar and Diving Program, May 8-11, Miami.*

Fluid and Electrolyte Balance for the Practicing Physician, May 8-12, Holiday Inn, Navarre Beach. For information: R. Douglas Collins, M.D., 1000 West Moreno St., Pensacola 32501.

Orthopedic Seminar, May 11, Mercy Hospital Conference Center, Miami. For information: James Jude, M.D., 3663 South Miami Ave., Miami 33133.

Pars Plana Vitreous Surgery — The Miami Technique, May 11-13, Miami.*

Update: Gynecological Endocrinology, May 13, Bay Harbor Inn, Tampa. For information: Robert W. Yelverton, M.D., 4700 N. Habana, Tampa 33614.

Clinical Family Planning for Physicians, May 15-16, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th St., Jacksonville 32209.

Family Medicine Update — 1978, May 18-21, Miami.*

7th Family Practice Review, May 22-26, Gainesville Hilton, Gainesville.**

JUNE

Review Course for Certification in Internal Medicine, June, Miami.*

The Private Practice of Psychiatry, June 8, Mercy Hospital, Miami. For information: Bernard Tumarkin, M.D., 3663 South Miami Ave., Miami 33133.

Bascom Palmer Eye Institute Alumni Meeting and Seminar, June 9-11, Miami.*

Florida Suncoast Pediatric Conference, June 12-14, Sheraton Sand Key, Clearwater.+

Coronary Disease, Exercise Testing and Cardiac Rehabilitation, June 23-25, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

Fifth Annual Postgraduate Seminar in Respiratory Care, June 23-25, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Seminar for Intensive and Critical Care Personnel, June 23-25, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

JULY

Examination of the Arterial System, July 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 522 West Highland Boulevard, Inverness 32650.

SEPTEMBER

Transient Ischemic Attacks: The Computerized EEG, Sept. 11, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.

Anesthesiology Review and Update, Sept. 15-17, Sonesta Beach Hotel, Key Biscayne. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

NOVEMBER

Adolescent Medicine, Nov. 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

DECEMBER

7th Annual Refresher Lecture Course for Nurse Anesthetists, Dec. 1-3, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

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There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

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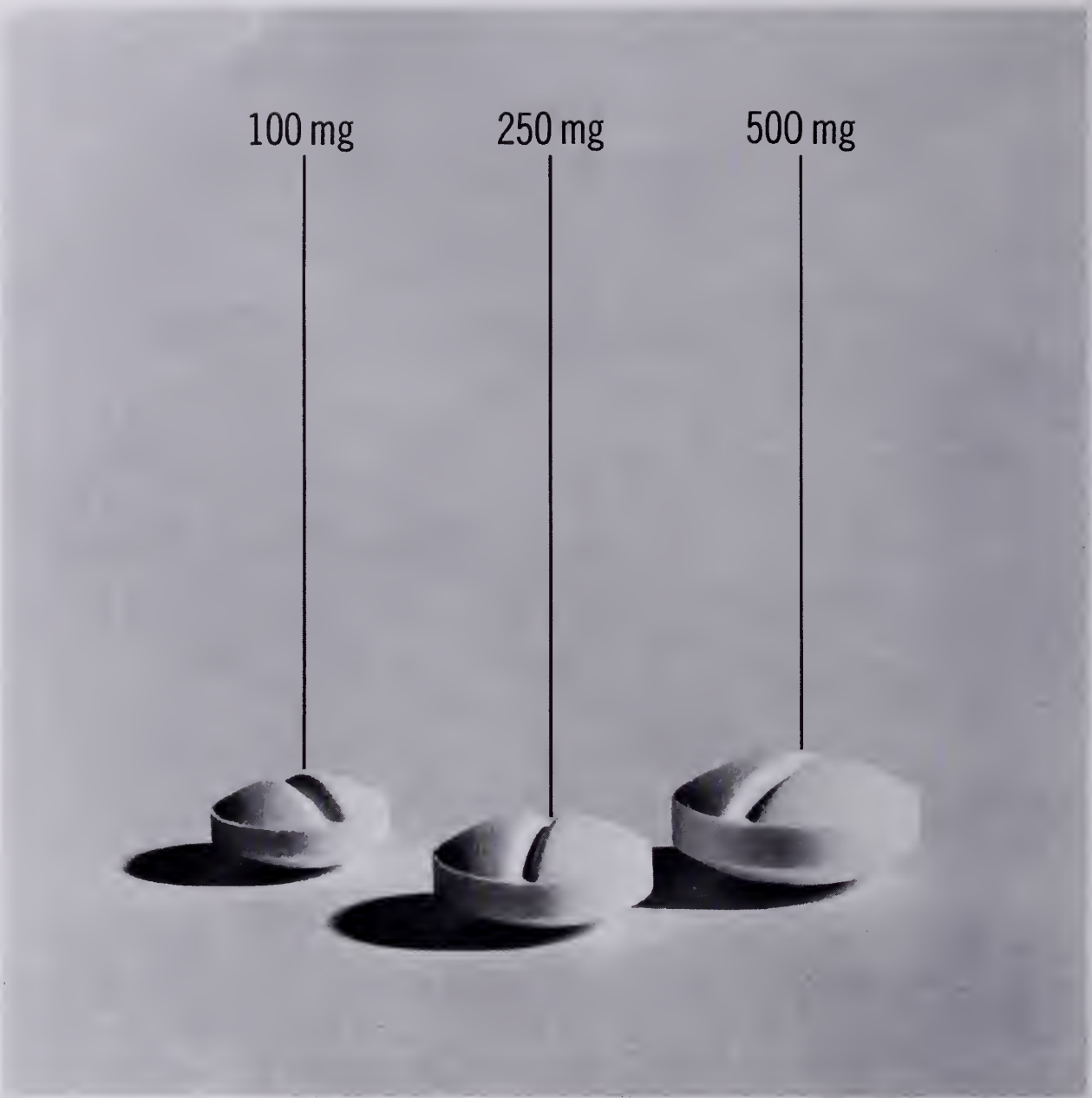
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INTERNIST/CARDIOLOGIST — 29, ABIM, Board eligible cardiovascular diseases, seeks group, hospital-based practice. Prefer Florida. Available July 1978. Contact B. Shah, M.D., 191 Willoughby St. #8F, Brooklyn, N.Y. 11201. (212) 270-4353.

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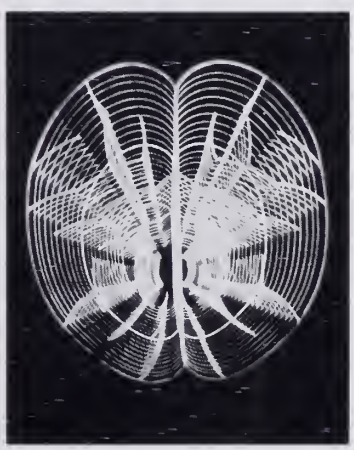
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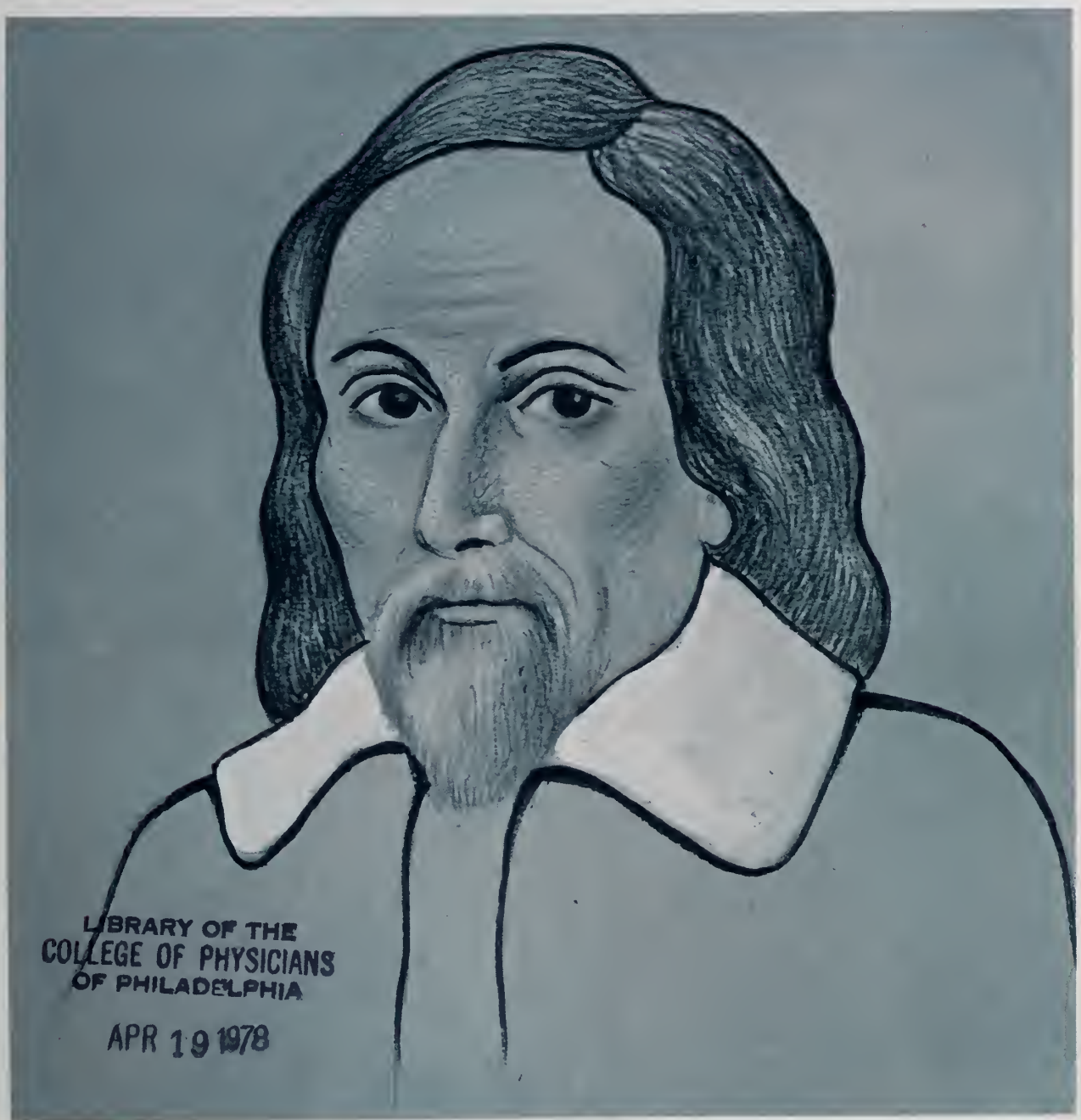
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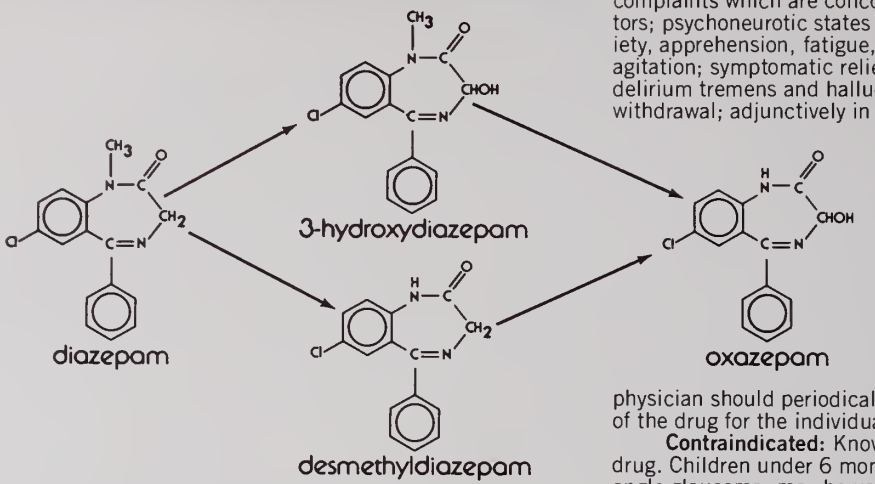
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APRIL COVER — The sketch of William Harvey is by Mr. Michael Schlazer of Panorama City, California, formerly from Miami. This is the third cover by Mr. Schlazer for The Journal. See "William Harvey Remembered," page 265 and "William Harvey," page 268.

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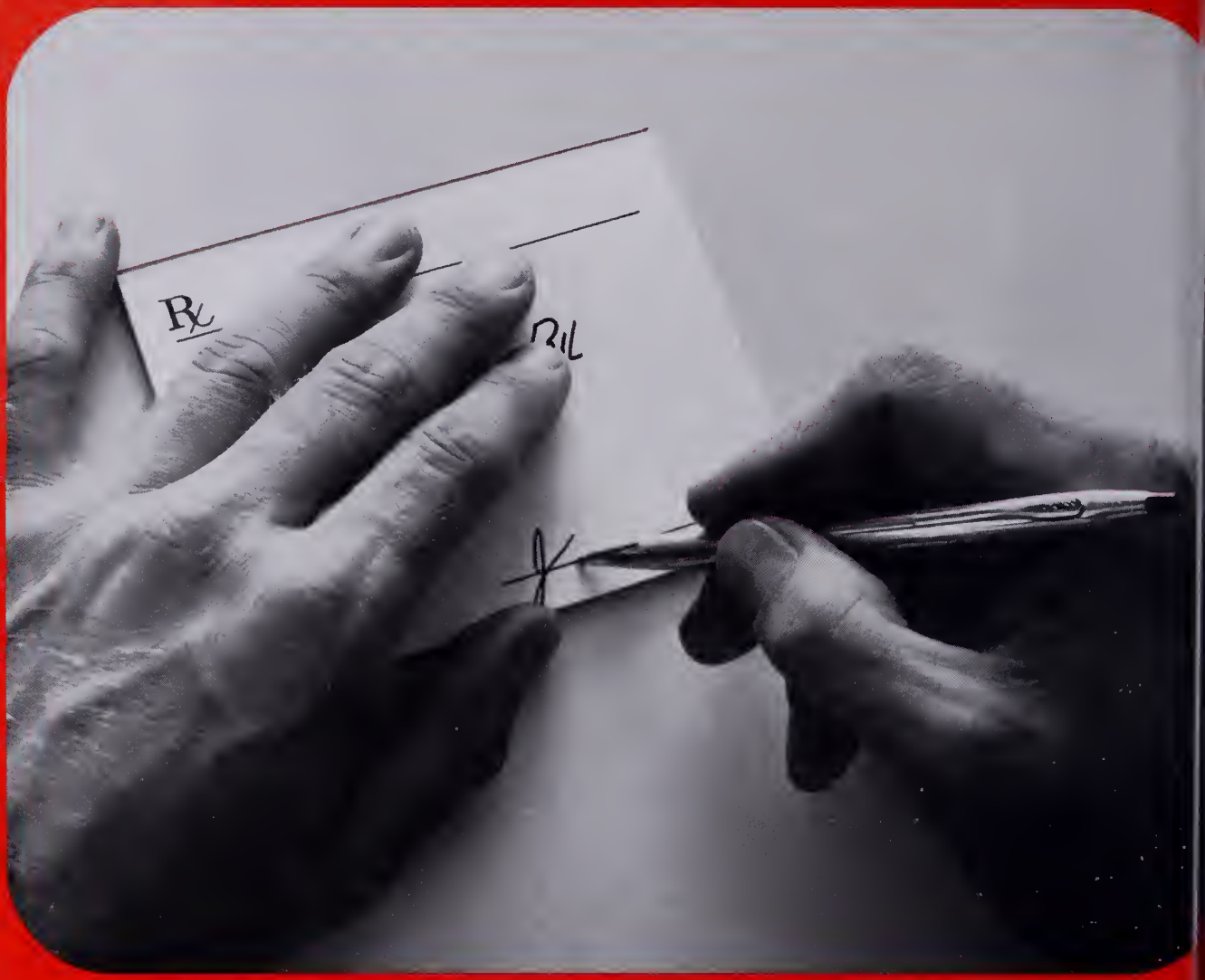
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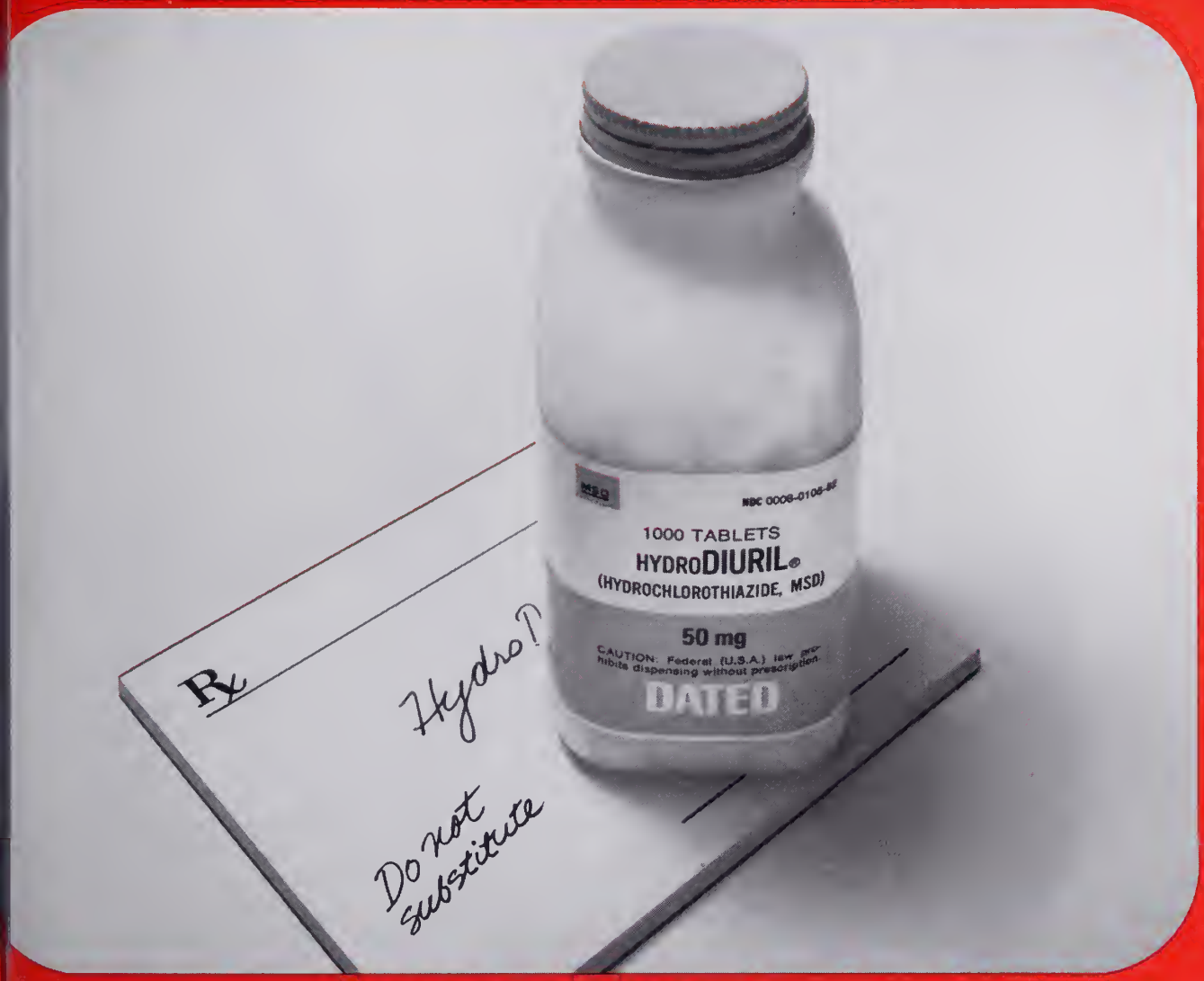
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Contraindications: Anuria, hypersensitivity to this or other sulfonamide-derived drugs.
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. *Nursing Mothers:* Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im

or experience—



or ours.

ment becomes evident, consider withholding or discontinuing etic therapy. Thiazides may decrease serum PBI levels without s of thyroid disturbance. Calcium excretion is decreased by zides. Pathologic changes in the parathyroid gland with hyper- emia and hypophosphatemia have been observed in a few patients prolonged therapy; thiazides should be discontinued before testing parathyroid function.

erse Reactions: *Gastrointestinal System*—Anorexia; gastric ir- ion; nausea; vomiting; cramping; diarrhea; constipation; jaundice ahepatic cholestatic jaundice); pancreatitis; sialadenitis.

ntral Nervous System—Dizziness; vertigo; paresthesias; headache; thopsia.

matologic—Leukopenia; agranulocytosis; thrombocytopenia; stic anemia.

diovascular—Orthostatic hypotension (may be aggravated by hol, barbiturates, or narcotics).

ersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing itis (vasculitis) (cutaneous vasculitis); fever; respiratory distress uding pneumonitis; anaphylactic reactions.

er—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; kness; restlessness; transient blurred vision.

enever adverse reactions are moderate or severe, thiazide dosage uld be reduced or therapy withdrawn.

e: When used with other antihypertensive drugs, careful observa- s for changes in blood pressure must be made, especially during al therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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TABLETS: 25 mg, 50 mg, and 100 mg

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Dean's Page

Off With Their Heads

Hollis G. Boren, M.D.

As we are all painfully aware, the cost of medical education is considerable. When the need to educate more physicians became generally recognized, one answer was to provide funds described by the unfortunate term capitation. Head counts of medical students in a variety of ways became the order of the day. How many new students matriculated? How many more new students have you taken this year? How many repeaters do you have? How many students graduated in three or four years? The answers to such questions were used to calculate how much money a given school was entitled to receive. And so medical students joined other beasts of burden in regard to being considered by the questions analogous to how many head of medical students do you have? For the moment at least we are not considered in terms equivalent to a side of beef or to a hind quarter of a donkey.

The federal government was the biggie in regard to capitation. All medical schools sought federal funds. Many state governments followed suit and provided separate and distinct capitation funds. There was only one fly in the ointment. There were never enough federal funds to provide the total amount to which a school was entitled. Nevertheless, that which was given was extremely valuable as it had a minimum number of restrictions with an accompanying low overhead cost.

Disaster hit when means of forcing medical schools to abrogate their most basic responsibilities by accepting HEW assigned quotas of United States citizens in foreign medical schools were sought. The answer was to cut off capitation funds to all schools that did not accept assigned quotas.

In the ensuing activities, a battle was won: a new law PL 95-215 replaced the old Health Manpower Bill of assigned quotas; HEW quickly got out of the student matching business; and all HEW lists with their implied hopes were rendered void. But a war may have been lost. For now capitation may be so massaged, so restricted, so altered as to lose its value, perhaps its viability. Indeed capitation may not survive at all. The situation may well become one which leads to the legislative mandate, "Off With Their Heads." Decapitation may be the order of the day. Let us hope that responsible legislators will not ignore the consequences of such precipitous action. The number of medical students, their faculty and support has increased significantly as a direct result of capitation funds. This system requires significant time to alter in any logical meaningful way. The withdrawal of capitation funds or their subversion to other mechanisms of financing medical education would in all likelihood not be replaced by other funding mechanisms. Can the state be asked to take up the slack? Can tuition be increased? How rapidly can the supply of physicians be reduced?

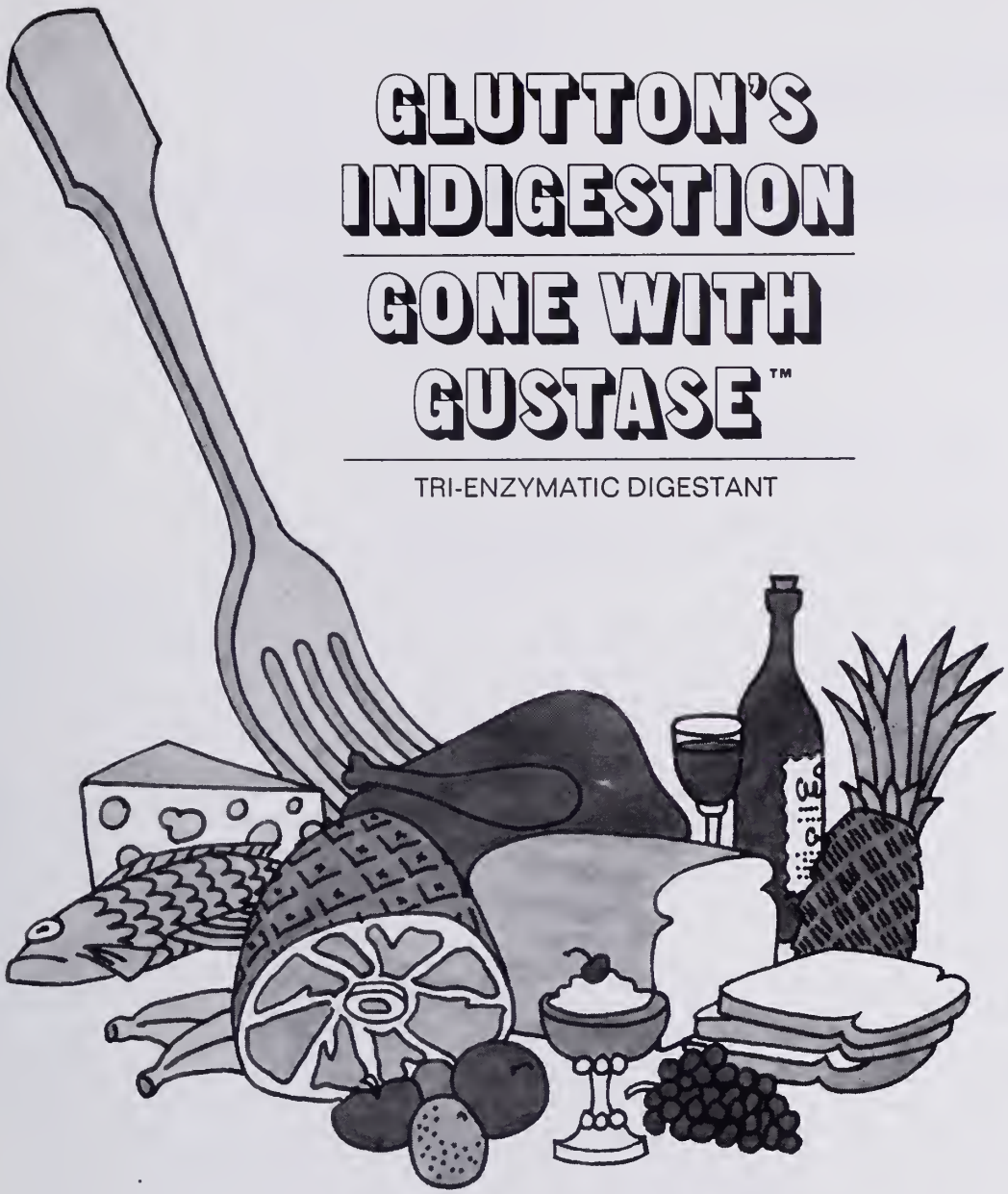
The consequences of altering capitation mechanisms are of sufficient gravity to demand great caution on the part of all concerned.

Dr. Boren is Director of the University of South Florida Medical Center and Dean of the College of Medicine, Tampa.

● Dr. Boren, University of South Florida, Tampa 33612.

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Each Gustase tablet contains: Gerilase (amylolytic enzyme) 30 mg., Geriprotase (proteolytic enzyme) 6 mg., Gericellulase (cellulolytic enzyme) 2 mg.

Gustase-Plus: Gustase components plus homatropine methylbromide 2.5 mg. and phenobarbital 8 mg. (warning: may be habit forming). Side effects: Blurring of vision or dry mouth may occur. Contraindications: Glaucoma, renal disease & idiosyncrasy to phenobarbital.

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Our new Medical Necessity Program has two worthy goals:

(1) To help contain costs.
(2) To upgrade medical care.

This program initially identifies 28 surgical and diagnostic procedures which will not be paid routinely by Blue Shield. All pertinent claims will be reviewed for medical necessity and covered only when a clear need can be proven.

Following is a list identifying the 28 surgical and diagnostic procedures:

1. Ligation of Internal Mammary Arteries, Unilateral or Bilateral
2. Radical Hemorrhoidectomy, Whitehead Type
3. Omentopexy — Portal Obstruction
4. Kidney Decapsulation, Unilateral and Bilateral
5. Perirenal Insufflation
6. Nephropexy
7. Circumcision, Female
8. Hysterotomy
9. Supracervical Hysterectomy
10. Uterine Suspension
11. Uterine Suspension with Presacral Sympathectomy
12. Hypogastric or Presacral Neurectomy
13. Fascia Lata by Stripper — when used to treat lower back pain
14. Fascia Lata by Incision — when used to treat lower back pain
15. Ligation of Femoral Vein, Unilateral and Bilateral — when used to treat Post Phlebitic Syndrome
16. Excision of Carotid Body Tumor — when used to treat Asthma
17. Sympathectomy, Thoracolumbar, Unilateral or Bilateral — when used to treat Hypertension
18. Sympathectomy, Lumbar — when used to treat Hypertension
19. Basal Metabolic Rate — BMR
20. Protein Bound Iodine — PBI
21. Icterus Index
22. Ballistocardiogram — BCG
23. Phonocardiogram with Interpretation and Report
24. Angiocardiography, using Carbon Dioxide, Supervision and Interpretation Only
25. Angiocardiography, Single Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
26. Angiocardiography, Multi-Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
27. Angiography — Coronary, Unilateral, Selective Injection, Supervision and Interpretation Only, Single View unless in an Emergency
28. Angiography Extremity

This program was developed in cooperation with The American College of Physicians, The American College of Surgeons and The American College of Radiology. We ask your support in making our Medical Necessity Program 100% effective.*

*A claims review by The Florida Plan indicated that most of the procedures were already being screened for medical need and few of the services in question were being performed in Florida.

Blue Shield of Florida

® Blue Shield Association

Time is the test of all things.

1954
1978



BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

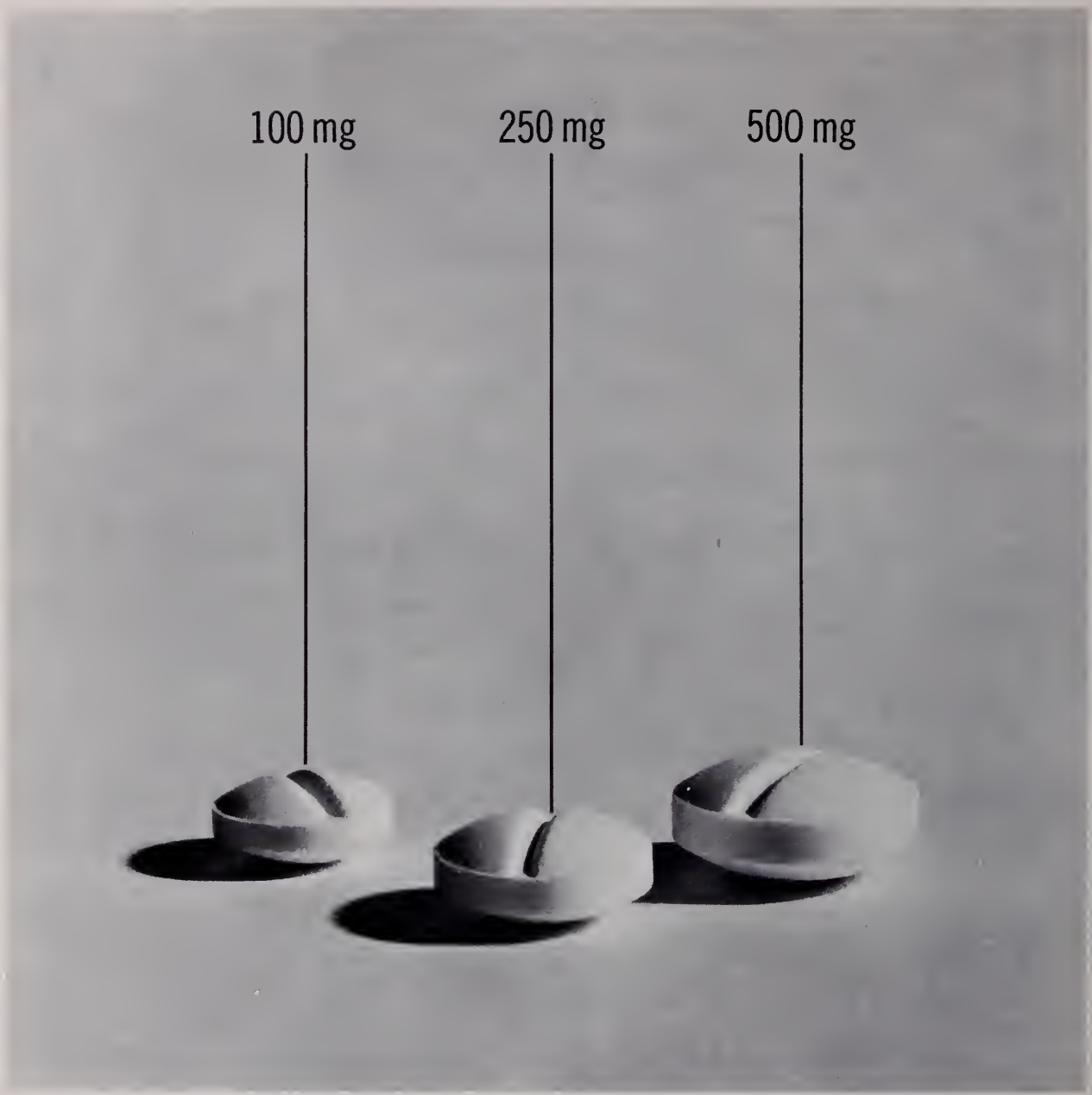
In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

Kaon® Elixir
potassium gluconate)
20 mEq per 15 ml

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RURAL HEALTH

A New Feature Begins

R. Edward Dodge, M.D.

The Rural Health column is a new feature in the Journal. It will appear from time to time, and will touch on various topics pertaining to health. The common thread running through these subjects will be that they are drawn from or have particular relevance to rural and small town settings. However, those who practice in metropolitan areas need not feel that this page is not for them. On the contrary, they are warmly invited to scan the Rural Health column regularly. Often the contents of the column will be of as much interest to urban readers as to rural readers.

About a year ago, a rural physician received a call from one of his patients. She and her husband were retired, living near a small town in central Florida. Her problem was not an uncommon one: her sister and brother-in-law were coming to stay with them. The brother-in-law was ill and would require medical attention. Would the doctor be willing to take him as a patient?

The doctor customarily tried to be helpful to families of his patients, so he agreed to accept the new patient; however, the degree of the brother-in-law's problems turned out to be staggering. J.J., as we will refer to him, was a 52-year-old executive who had suffered a severe stroke three months earlier. He had subsequently required surgical placement of a cerebrospinal fluid shunt because of a ventricular block. However, in spite of all therapeutic efforts, he remained almost a quadriplegic, being capable of only minor motor function with his right arm and leg. He had been maintained on intravenous fluids for several weeks and was emaciated. He was also almost completely aphasic. As if these problems were not sufficient challenge, he had developed a large, deep decubitus ulcer during his preceding hospitalization. It was located in the right lateral gluteal area, and measured about 12 cm. in diameter. Finally, he had developed a chronic, resistant urinary tract infection, the result of an indwelling Foley catheter.

The physician's first reaction after examining the patient was that he should be cared for in a nursing home. However, the family was firm on this point: they would do whatever the doctor ordered for his care at home but they would not place him in a nursing home.

Over the next few months, the doctor supervised J.J.'s home care program, making home visits at times, and giving instructions by phone at other times. J.J.'s wife and sister-in-law were not trained nurses; however, they rapidly learned how to give him nursing care which was excellent, perhaps not least because it was loving care. They learned how to dress his decubitus ulcer, give him good skin care, and change his position frequently. They tended to his personal needs, improvising an in-place urinal with which they successfully caught most of his urine. (After the Foley had been dispensed with, the urinary tract infection was finally conquered.) They exercised his limbs, in accordance with the instructions of the physical therapist from the local hospital. They spoon fed him nutritious foods, which they prepared in as tasty a manner as possible. Above all, they surrounded him with loving care as they worked with him, fed him and tended to his needs.

The result of all this loving care was slow to unfold, but was little short of miraculous. The huge decubitus ulcer, which had required extensive debridement, gradually healed. J.J. slowly took an increasing interest in his surroundings, and began to react to his wife's and sister-in-law's chatter with

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Dr. Dodge is Chairman of the FMA Committee on Rural Health and President of the Florida Committee on Rural Health.

one or two-word responses which were amazingly appropriate. He began to gain weight and to look better. He became capable of more movement with his right arm and leg, and then with his left arm. Eventually the day came when he was fitted with braces, and was actually able to stand with help. By this time, J.J. and his wife had returned to their own home elsewhere, J.J.'s wife having concluded that she was now able to care for him. J.J. was still far from a totally rehabilitated person; nevertheless, he had made remarkable gains in his convalescence, gains which the rural doctor caring for him would have judged impossible to begin with.

There are several points worth making from this true story. First and foremost, this is a story of the remarkable power of a family's love for one of their stricken members. As another doctor who was familiar with the case said, "If I ever have a stroke, I hope my family loves me that much." However, it is not an isolated example of family love. Every family doctor can relate stories of families who tenderly care for terminally ill or chronically invalid patients at home over long periods of time. In rural areas particularly, they often do so with a minimum of outside supportive services, simply because such services are scarce.

Secondly, it is readily apparent that the monetary cost of caring for J.J. at home was a small fraction of the cost it would have taken to provide similar care in a nursing home. In fact, even though he had no professional nurse attending him, J.J. received care which was superior to any he could have purchased in the finest of nursing homes.

Thirdly, and finally, the story of J.J. illuminates the inherent weakness of attempts to improve personal health care by means of legislation. Laws and regulations are obviously necessary, but neither PSRO nor National Health Planning guidelines, nor any other kind of legislative measure will ever be able to provide what J.J.'s family provided for him — a caring milieu in which he was surrounded with lots of tender love. This will be forever true, for the simple reason that love cannot be legislated.

• Dr. Dodge, 511 North Highland Boulevard, Inverness 32650.

No man who is occupied in doing a very difficult thing, and doing it well, ever loses his self-respect.

George Bernard Shaw

Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

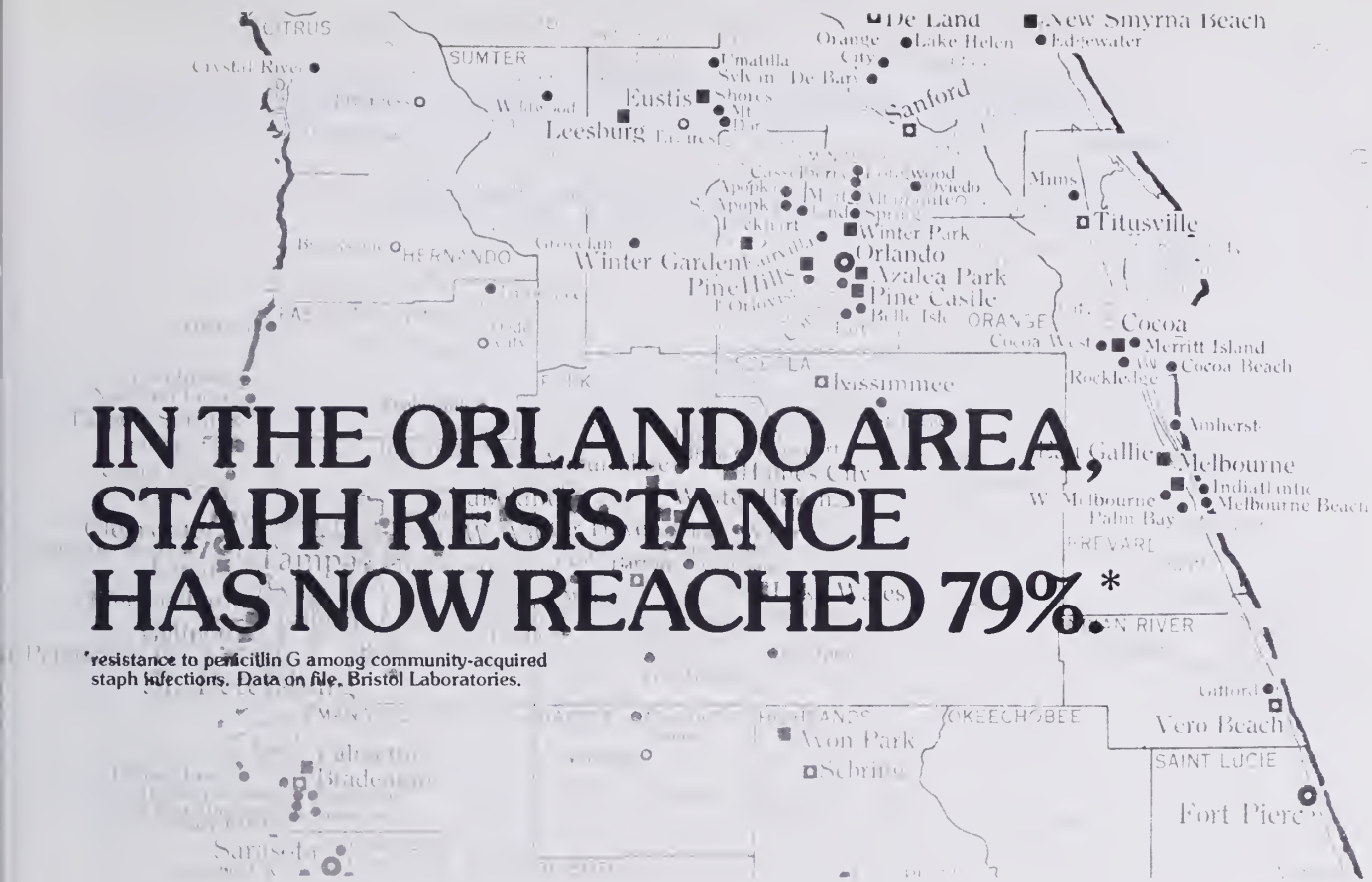
Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

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IN THE ORLANDO AREA, STAPH RESISTANCE HAS NOW REACHED 79%.*

*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

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(cloxacillin sodium)

..."THE PENICILLIN OF TODAY"

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of in *vitro* data is unknown.

- 10 times more active against strep than staph.
- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary for prescribing information.



FROM THE EDITOR'S DESK

Americans have mixed moods about national health insurance when financing is mentioned. Washington Post writer Daniel S. Greenberg cites polls that show that 67% of the public see a need for NHI; however, NHI's popularity drops to 40% when the issue is tied to higher taxes. Greenberg points out that the polls were taken before Social Security taxes were raised the last time.

Four national health insurance proposals were reviewed in February by the National Advisory Committee for NHI. They were: (1) the "publicly guaranteed health protection" plan run by the government but with a proviso allowing employers and individuals to buy approved private insurance; (2) the "quasi-public corporation" plan, essentially the labor bill; (3) the "target" plan calling for a federal catastrophic program, a new program to replace Medicare and Medicaid, a new program for children, and federal standards for private insurance; and (4) the "consumer choice" plan, establishing a national set of benefits and premiums modeled on the health insurance program for federal employees. It is designed to encourage competition and growth of HMOs.

The Defense Department has asked Congress to abolish the position of Assistant Secretary for Health Affairs. The office's functions would be transferred to the Office of the Secretary. Various health organizations have supported consistently a high-ranking office for health affairs in the Department.

The American Hospital Association has urged its members to oppose a plan for standby federal controls on hospital revenues. Under the standby plan of Rep. Dan Rostenkowski, Chairman of the Ways and Means Subcommittee on Health, federal controls would take effect if the voluntary effort for restraints failed. AHA said such a standby program would have an adverse impact on the efforts already underway in the Voluntary Effort for Hospital Cost Containment. AHA also said that arbitrary caps on hospital revenues "are tantamount to wage/price controls on one segment of an industry and, as such are inequitable and administratively unworkable."

Hospital costs in Maryland rose 9.7% last year, well below the national average. The state's Health Services Cost Review Commission said efficient budgeting and reduction in labor costs were the main reasons. Forty-five hospitals made a profit for the year while 10 others had net losses.

The AMA Education and Research Foundation will fund and co-sponsor four student research forums this year, including one in Florida. A national forum will be held in Galveston, Texas, while regional events will be conducted in Miami, Omaha, and Carmel, Okla. Faculty advisor for the program is Edward N. Brandt, Jr., M.D., Vice President for Health Affairs of the University of Texas System and Vice Chairman of the AMA Section on Medical Schools.

A British national health service seminar will be sponsored by the AMA in London, May 12-17. The program is open to a limited number of state, county and specialty society executives, medical writers, and physicians representing specialty, state and county organizations.

Miami Beach's Eden Roc Hotel will be the scene for one of four Medical Staff Leadership Seminars sponsored by the AMA this year. The program will encompass medical staff responsibilities, JCAH standards, medical staff by-laws, privileges for nonphysician professionals, hospital foundations, health systems agencies and other topics. Fees are $150 for AMA members and medical society staff, $200 for nonmenbers. The program is acceptable for 14 hours of AMA Category 1 credit. The Miami Beach program is scheduled for November 3-4, 1978.

The Editor

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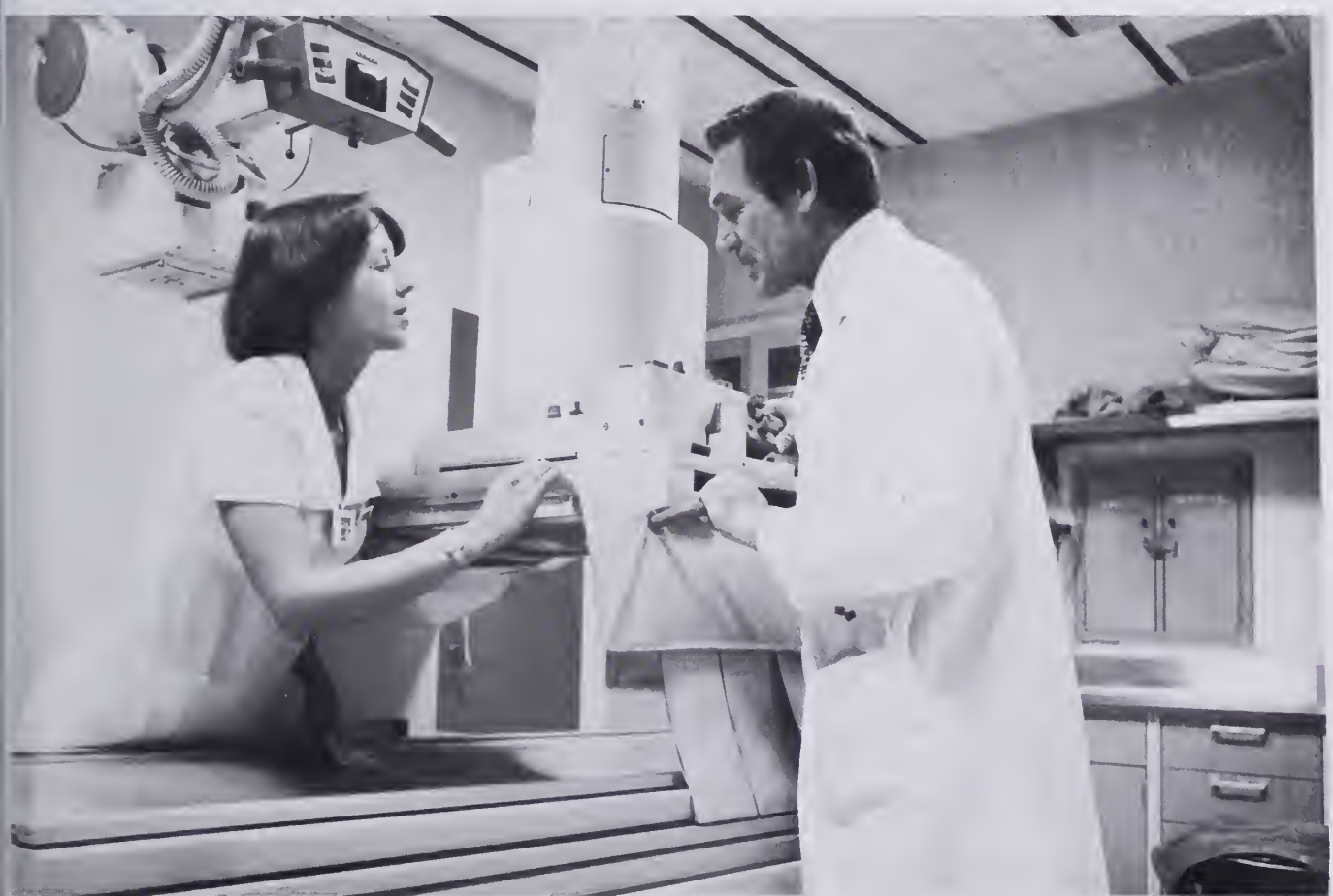
When you're established, he can help you grow. With construction or mortgage loans. Low-cost expansion loans. Financial counsel and assistance in setting up a partnership or professional corporation. New equipment leasing. Patient financing through Master Charge or BankAmericard. Corporate trust services. And much more.

And later he can offer you a broad range of personal banking services you'll need as a successful practitioner: including advice on trust and estate planning and bond and money market investments.

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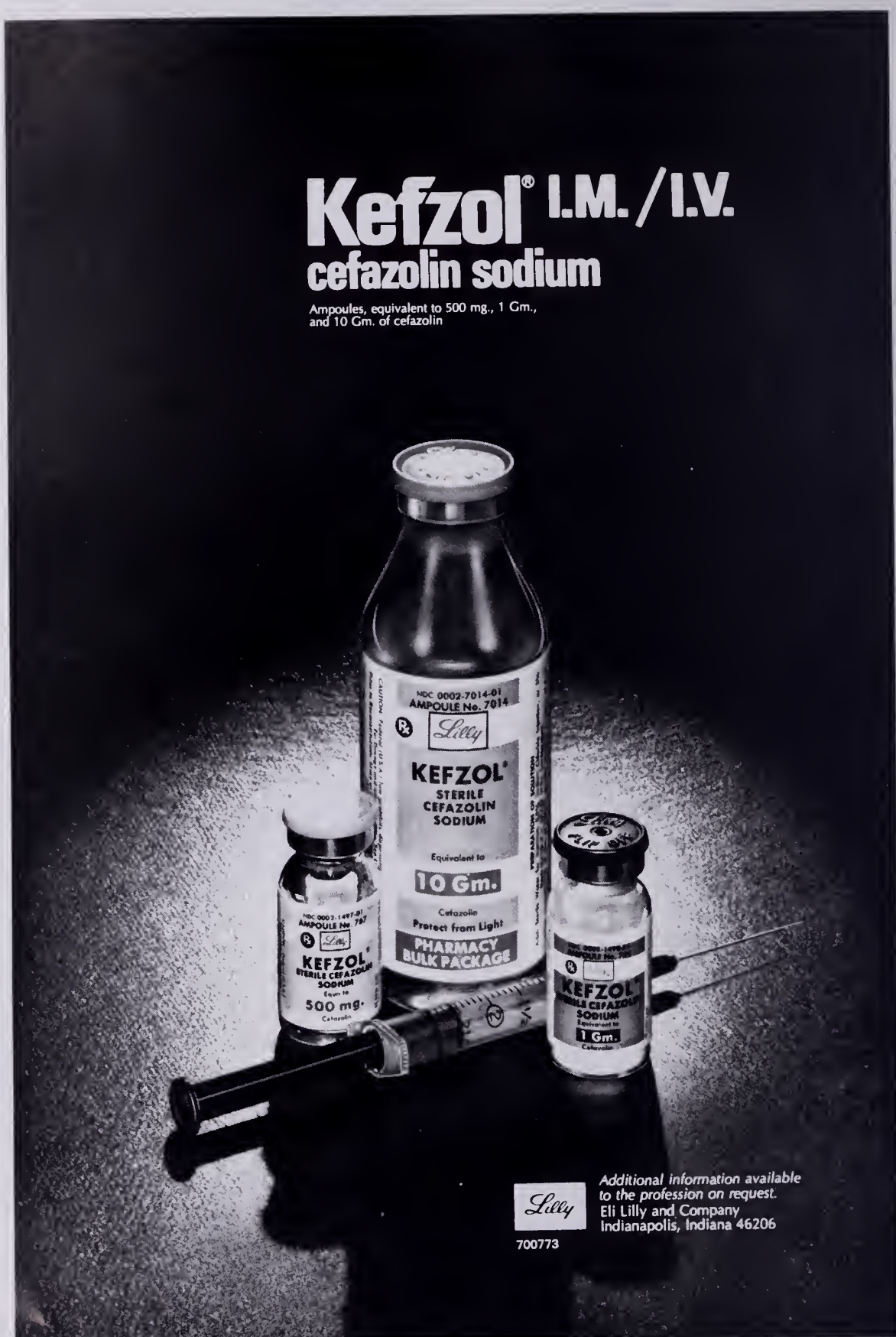
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Two to three 8 oz. glasses per day.

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Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

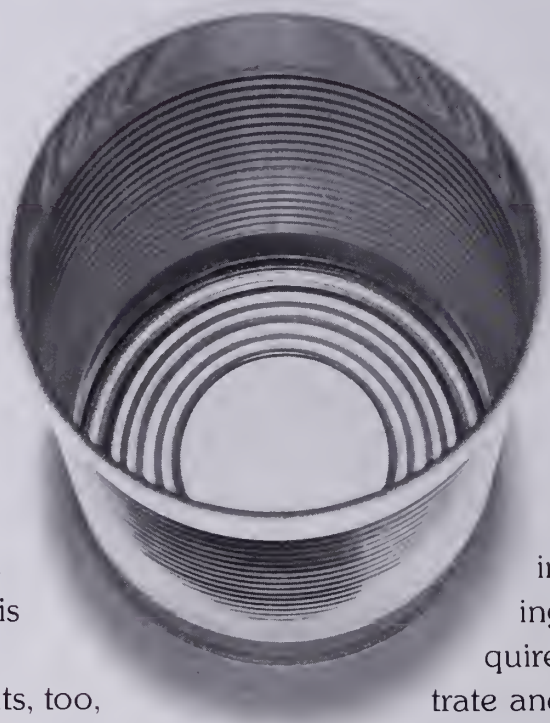
	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on: 60 mg tryptophan=1 mg niacin

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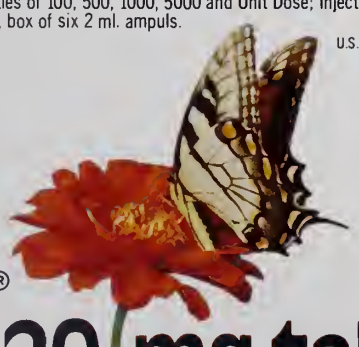
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Infant Nutrition

Lewis A. Barness, M.D.

Nutrition remains a cornerstone in the well-being of infants for the first years. Many believe that early nutrition and establishment of good feeding practices may influence the later development of the child, even to the extent of affecting the onset of degenerative diseases in later life. All those providing medical care for children can and should provide information to parents regarding present understanding of infant nutrition in the hope that some illnesses in children may be lessened and the goals of prolonged better health attained.

For the past several decades infant feeding practices have been largely directed by parents who have occasionally based these practices on unsound information. While in most instances such happenstance practices have resulted in infants who thrive, some instances of illness could have been prevented had more careful practices been instituted early in life. The large majority of infants are resilient and can correct minor errors in nutrition. For the 5% or 10% of infants who are more subject to illness, early aids may avoid the illnesses.

Breast Feeding?

For eons it was recognized that newborn infants lived only when fed breast milk. With technical advances in artificial formula making and adequate refrigeration, over the last 30 or 40 years it was widely believed that infants thrived equally well when nourished with breast milk or simulated human milk formulas. Even the most recent studies comparing breast and bottle-fed infants indicate that in a highly developed area, Cooperstown, New York, breast-fed infants have a significantly lower morbidity than those fed simulated human milk formulas.[1]

Among the advantages of breast milk are the following:

Breast milk is less likely to be associated with allergic manifestations in infants. It has been suggested that the lower level of casein and the unique qualities of human lactalbumin are responsible for the lower allergenicity compared with cow's milk or soybean protein.[2]

Iron in breast milk is readily absorbed; that in cow's milk formulas is less easily absorbed.[3] Evidence has been presented to indicate that even though breast milk contains little iron, breast-fed infants not supplemented with iron-containing foods are unlikely to become iron-deficient or anemic. Bottle-fed infants must receive iron supplementation to prevent anemia not only because nonhuman milks contain little iron but also because excessive ingestion of unmodified cow's milk may cause gastrointestinal bleeding.

Zinc and perhaps other trace minerals are also more readily available from breast milk than other milks.[4] Infants with acrodermatitis enteropathica, a severe and often fatal diarrheal disease, frequently survived when fed breast milk but not other milks. Initially this was attributed to the essential fatty acid content of breast milk. Subsequently, it was recognized that this condition was associated with zinc deficiency secondary to poor absorption of zinc in formula-fed infants; zinc absorption was found to be facilitated in breast-fed infants, accounting for their survival.

Breast-fed infants have increased resistance to gastrointestinal and respiratory infections. This is and probably will remain for some time the least likely to be duplicated property of formulas. Specific antibodies which effectively suppress viruses and bacteria in the intestinal tract, e.g. IgA, nonspecific factors such as lysosyme and lactoferrin, as well as human macrophages in human milk which grow in the intestinal tract help improve resistance to infections. Artificial or synthetic sources of these substances do not seem to be on the horizon.[5]

From the Department of Pediatrics, University of South Florida College of Medicine, Tampa.

Cretinism may be mitigated by breast feeding, perhaps because of significant thyroid hormones in milk.[6] Low birth weight infants also seem to benefit from fresh breast milk. The better response of low birth weight or prematurely born infants has been attributed to the presence of specific antibodies, the unique characteristics of the protein and fat, or the lower osmolality of human milk.

Less certain advantages of breast feeding have been suggested. Emotional attachment of the infant and parents can be equal whether the infant is bottle or breast fed. Obesity seems less frequent in breast-fed infants but can occur. Calcium absorption, which is poor when cow's milk is fed, is corrected by presently available formulas. The protein content in formulas is lowered to approach that of human milk and the carbohydrate is limited to lactose which produces an acid milieu in the intestine. Scurvy and rickets which are rare in the breast-fed infant[7] are eliminated in the simulated human milk formula-fed infants since these contain added vitamins C and D.

What Can the Doctor Do?

The most positive influence in the encouragement of breast feeding is in the hands and thoughts initially of the obstetrician. The most negative influences have been found to be discouragement by the obstetrician or the nursery nurses. Many pediatricians also have not encouraged nursing, and this negative or neutral feeling has been transmitted to mothers. Encouragement by the pediatrician, husband, grandmother, and others helps, even though many of these may have been bottle fed.

The recent increase in the number of nursing mothers compared to the last two decades indicates that society is ready to accept nursing after a 20 year decline. First started in the middle and upper classes, nursing has been accepted by the activist groups, and more recently by some of the lower socioeconomic families. Nursing mothers may have problems which differ from those of bottle-feeding mothers. Encouragement and support by the obstetrician, nurses, and physicians caring for the children are necessary. Convincing mothers with fissured nipples or breast abcesses to continue nursing is difficult, but suitable shields or antibiotics can help. Explanation of the benefits of nursing to the baby frequently overcomes the mother's doubts.

Some mothers will not nurse. Social, psychological, economic, and health reasons may prevent nursing. Such mothers should be advised to use a formula which closely simulates human milk, in which the protein and electrolyte contents are lowered, where the saturated fat has been replaced with polyunsaturated fats, and where the formula is supplemented with iron and vitamins.

Breast feeding or formula feeding continues until the baby conveniently drinks from a cup and eats a varied diet, usually at 9-12 months of age.

Solid Feedings

The time for introducing solid feedings has been clouded by social, sociological, and developmental considerations. Early introduction of solid feedings has no known nutritional basis for infants fed human milk. Human milk apparently contains sufficient nutrients as a sole food until nine to 12 months of age. Cow's milk or formulas may not be complete foods; for example, zinc, iron and vitamin D supplementation is needed. Other deficiencies may be found but, as stated by the Committee on Nutrition of the American Academy of Pediatrics in 1958, there are no known advantages to introducing solid feedings before 3-4 months of age or even later in the breast-fed.

There are recognized harmful effects of early introduction of solid foods. The more foods introduced in the first six months of life, the more likely the development of food and other allergies either in the infant or later.[8] Many of the home prepared foods and some of the commercial foods may contain excessive quantities of salt. Some evidence in animals indicates that early introduction of high salt foods is related to later hypertension. Feeding an infant who cannot support himself properly in a sitting position is difficult and frequently results in an unnecessary battle. Obesity in infancy can be harmful to the infant himself even if later obesity is avoided. Obese infants, it has long been recognized, combat respiratory infections much less well than lean ones.

Doctors must convince parents that there are no known advantages to early introduction of solid feedings and some undesirable effects. Solid feedings may begin at 3-6 months of age and should be with single foods. Rice cereal can be started at 3-6 months, followed by single fruits such as apple, pears, peaches at 4-7 months, vegetables such as peas, beans, carrots at 5-8 months, meats such as beef, lamb, liver at 6-9 months, egg yolk at 7-10 months, and then finger foods or junior foods. No new food should be introduced more frequently

than one each week. Such a regimen should decrease the incidence of infantile diarrhea as well as food allergies.

Colic

Colic is a poorly defined syndrome in which the baby, two weeks to two months of age, seems to have abdominal pain, draws his legs up, becomes distended, and may pass flatus. Crying decreases usually when the baby is given more attention. The syndrome disappears spontaneously at about three months of age.

Causes of this syndrome are largely unknown. Of the known nutritional causes that produce such irritable infants, the most common is overfeeding and the next most common is underfeeding. Therefore, it behooves the physician first to get an accurate dietary feeding history. Too frequent or too sparse feedings also may contribute. Food intolerance may be a cause of colic but changing the diet should not be tried until other causes are eliminated.

Diarrhea

Diarrhea is the presence of loose, watery stools. Infants normally may have as few as one stool every three days up to eight stools daily. Frequent stools can be normal and do not indicate diarrhea.

Diarrhea can have multiple causes. In infancy the most common cause is overfeeding, but underfeeding, viral or bacterial gastroenteritis, food intolerance of multiple etiologies, irritable colon, cystic fibrosis of the pancreas, neural tumors and others may cause diarrhea.

In the treatment of diarrhea, the infant's hydration must be maintained. If diarrhea is severe, parenteral fluids are required.

In mild diarrhea or in realimentation after diarrhea has lessened, clear fluids should be given followed by slow reintroduction of the previous diet. After the onset of diarrhea, lactase disappears from the brush border of the intestine making the infant temporarily intolerant to lactose and the intestine wall becomes more permeable to protein. Many with food allergy can date the onset of the allergy to an episode of diarrhea. Therefore, a varied diet should not be reinstituted until several days after the diarrhea has ceased.

Juices

The purpose of fruit juice in the infant diet is simply to vary the diet. Fruit juices contain vitamin C but this is available from other sources. Fruit juice, even natural fruit juice, has a caloric density almost equal to that of milk or formula, and these calories are mainly composed of carbohydrate. Therefore, early introduction of juice may displace other needed calories.

Bottles containing formula or juices should not be used as pacifiers. The practice of feeding fruit juice through a nipple and bottle is bad, as this may be used as a pacifier which keeps a high carbohydrate mixture near the budding teeth and contributes to "milk-bottle caries."

Caries

Two factors have helped reduce the incidence of caries. In areas where the water supply is fluoridated, caries is decreased. If the water supply is not fluoridated, infants should be given fluoride drops to contain about 0.25 mg. daily.

Parents should be warned about milk-bottle caries. When the bottle containing milk or sweetened liquids is kept in the mouth for long periods, development of caries is encouraged. Pacifiers or bottles containing only water should be used for those infants who have extra need for sucking. Weaning from bottle or breast can be accomplished at 9-12 months. Unsweetened water should be given to satisfy thirst.

Skim Milk

Concerns about obesity and saturated fatty acids have led some to recommend skim milk in the diets of infants. This can be dangerous, especially in infants less than a year of age.

Obese infants should not be made to reduce, but to limit the rate of gain. This is a more satisfactory and less potentially harmful method of producing a more desirable physiognomy. This can be accomplished by decreasing the caloric density of nutritionally good foods. If one ounce of water is added to 4 ounces of complete formula, the caloric density is equal to that of 2% skim milk, and generally satisfies the hunger of an infant at this lower caloric intake. Water can be given between feedings or mixed with solid feedings.

In contrast, skim milk has produced a high osmolar load for the infant and satisfies neither thirst nor appetite. Therefore, infants can drink large quantities of this fluid consuming a high electrolyte high protein unbalanced diet. The danger of developing hyperelectrolytemia with subsequent ill effects such as diarrhea or brain damage is real. Dangers are lessened with 2% milk, but use of this is also unnecessary. After the age of a

year or two, if the diet is sufficiently varied and the child does consume large quantities, skim milk may be safe. Skim milk should not be used for realimentation following diarrhea.

One proposed purpose for the early introduction of skim milk in the infant diet is to lower the saturated fat in the diet. Both human milk and simulated human milk formulas contain considerable polyunsaturated fat. Furthermore, in reviewing the use of fats in those with hyperlipoproteinemia, the Committee on Nutrition of the Academy of Pediatrics found no good reason to limit type or quantity of fat at such an early age even in high-risk infants. As information accumulates, it may be found that low saturated fat intakes are desirable for the older child, but as yet no good information warrants such a recommendation.

Milk Intake

During the first year of life, infants require 100-120 kcal/kg/day. Milk supplies about 67 kcal/dl or 670 kcal/liter or quart, sufficient for about a 7 kg or 15 pound infant. This is usually the maximum recommended intake of breast milk or formula, and additional calories are supplied by other foods. Thus at one year a 10 kg (21 pound) infant gets about two thirds of his calories from breast milk or formula. When the infant is weaned to whole milk, a more varied diet is desirable. This can be accomplished by limiting cow's milk to 500 ml (1 pint) a day. Such infants and children will then seek more varied sources of calories, some of which will contain iron.

Conclusion

All who care for infants can help prevent diseases of infancy by recommending good nutritional practices. Most important is the recommendation by obstetricians, nurses, pediatricians and other primary care physicians that breast feeding be utilized for 9-12 months. If the mother will not or cannot nurse, those formulas which most nearly simulate human milk with added vitamins and iron should be utilized.

Solid feedings should not be offered until 3-6 months of age, and should be introduced singly. Overfeeding and underfeeding should be avoided. If diarrhea develops, solid feedings should be reintroduced singly.

Juices are largely carbohydrate, should not be given early, and preferably should not be given by a bottle. No carbohydrate containing solution, including juices or formula, should be used as a pacifier. The infant should be given his feeding and the bottle removed from the mouth to prevent bottle caries.

In areas where the water supply is not fluoridated, the infant should be given fluoride drops.

Skim milk is dangerous if used as a major nutrient in the first year of life because it provides an unbalanced diet with a high protein and high electrolyte load. Other nutrients can accomplish better the desired effects of skim milk.

After weaning, which should occur at 9-12 months, whole cow's milk intake limited to one pint daily (500 ml) encourages the infant to consume a varied and balanced diet.

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● Dr. Barness, University of South Florida, Tampa 33620.

I never made a mistake in my life; at least, never one that I couldn't explain away afterwards.

—Rudyard Kipling

The Challenges of Cystic Fibrosis

Michelle M. Cloutier, M.D., and John A. Mangos, M.D.

Abstract: Cystic fibrosis is an autosomal recessive genetic disorder of the exocrine glands which has a frequency of approximately 1:1,500 live births. This disease presents challenges to the physician and the health care team. The Pediatric Pulmonary Center at the University of Florida in Gainesville, in coordination with Cystic Fibrosis Centers and Clinics throughout the state, is helping physicians and patients to recognize and manage this chronic disease.

Cystic fibrosis (CF) is a generalized disorder of the exocrine glands. It is the most common, lethal inherited disease of Caucasians and is the cause of most of the chronic, progressive pulmonary disease encountered in children. CF is inherited as a simple, autosomal recessive trait. In the white population in the United States it occurs in approximately one out of 1,500 live births and has a heterozygous gene frequency of about one in 20 of the total white population. Although the incidence of CF in nonwhite populations is considerably less than in the white population, it does occur in Blacks, Orientals, Africans and American Indians.[1]

The disease was first fully described in 1936 with the pathologic description of dilated ducts and fibrotic changes in the pancreas and intraluminal obstruction by copious secretions in the bronchial tree.[2] The nature of the genetic abnormality and how it produces the pathologic changes is not known. The mucous glands in the tracheobronchial tree, pancreas, salivary glands and gastrointestinal tract secrete an abnormally thick mucus. This thick mucus obstructs the pancreatic ducts causing acinar dilatation and rupture. This results in atrophy and fibrosis of the acini with subsequent loss of pancreatic proteolytic enzymes. Similarly in the lungs the thick, sticky mucus obstructs bronchioles. Infection soon follows, and a vicious cycle of obstruction, chronic infection and tissue damage occurs. Bronchiectasis, bronchiolectasis, peribronchial fibrosis and airway obstruction lead to a progressive loss of respiratory function and eventually to death. Respiratory insufficiency is the cause of death in over 90% of patients with CF.[1] In the sweat glands an increased concentration of sodium and chloride was first discovered in 1953.[3] This elevated salt concentration in the sweat has proven to be the basis for a reliable diagnostic test for cystic fibrosis — the sweat test.

Clinically, cystic fibrosis may present under many disguises. In the newborn infant, the abnormal mucus and lack of pancreatic proteolytic enzymes may result in a form of intestinal obstruction called meconium ileus. Later in life intestinal obstruction ("meconium ileus equivalent") may also occur secondary to inspissated, fecal material. Symptoms involving the gastrointestinal tract include frequent, bulky, malformed and malodorous stools. Rectal prolapse occurs in about 20% of the patients. Ten percent of patients with CF, however, have no evidence of pancreatic insufficiency, and therefore no gastrointestinal manifestations of the disease. These patients may even have normal growth. Liver disease may slowly evolve from biliary obstruction culminating in biliary cirrhosis in a small number of older patients. As in the gastrointestinal tract, the respiratory symptoms and signs range from occasional cough and recurrent respiratory illness to frequent paroxysms of severe cough, wheezing, dyspnea, diffuse coarse rales, increased anteroposterior thoracic diameter and clubbing of the fingers and toes. Nasal polyps develop for unknown reasons in 10-15% of patients. Chronic pansinusitis occurs in almost all patients. Obligate heterozygotes (e.g. parents of children with CF) are free from symptoms, show no evidence of increased mortality and have normal pulmonary function.

Cystic fibrosis presents four challenges to professionals in health care: (1) Diagnosis may be difficult if the wide spectrum of clinical manifestations is not appreciated; (2) Treatment is complicated and frequently uncertain because the variability in disease expression makes controlled studies difficult; (3) Research progress has been arduous because fundamental understanding of exocrine gland chemistry and physiology has required development and exploration; (4) Helping patients and their families to live with this chronic disease requires considerable time and attention.

From the Department of Pediatrics, University of Florida College of Medicine, Gainesville.

The Challenge of Diagnosis

Few diseases present at so many different ages as does CF. The manifestations and their combinations can only suggest the diagnosis which then must be confirmed. The definitive test for cystic fibrosis is the quantitative pilocarpine iontophoresis sweat test first described by Gibson and Cooke in 1959.[4] At least 50 mg of sweat must be collected for reliable results and the chloride concentration titrated. The chloride electrode method and the conductivity method are not suitable either for screening or diagnostic purposes because of the high frequency of false positive and false negative results. Children in whom a diagnosis of CF was made using these methods should have a repeat sweat test by the quantitative pilocarpine iontophoresis. The quantitative sweat test is readily subject to many technical errors and distortions. It must, therefore, be performed by highly skilled individuals who are involved in its frequent performance and who are familiar with the sources of errors. Chloride values consistently above 60 mEq/L are diagnostic of CF. A few rare diseases in children may be associated inconsistently with an abnormal sweat test, including severe malnutrition, myxedema, hyperhydrotic ectodermal dysplasia, nephrogenic diabetes insipidus and adrenal insufficiency.[1] None of these diseases, however, usually presents a problem in differential diagnosis. Occasionally borderline values (50-60 mEq/L) may need to be repeated over a period of many months before a definitive diagnosis is made. The sweat glands in newborns are immature and testing before the age of three-six weeks requires careful technique and repetition. There is no relationship between the sweat chloride concentration and the severity of the disease. The sweat chloride concentration gradually increases with age, but values above 70-80 mEq/L in adults are abnormal. (Refer to the report of the Commission of National Academy of Sciences in the Journal of Pediatrics, April 1976.) In addition to a positive sweat test, one of the following criteria is helpful for diagnosis: (1) A positive family history of CF, (2) evidence of pancreatic insufficiency or (3) evidence of chronic pulmonary disease. All siblings of patients with CF should have a sweat test performed even if there is no evidence of pancreatic insufficiency or chronic pulmonary disease since these individuals have a 25% chance of also having CF. (Short of duodenal intubation with measurement of pancreatic trypsin and chymotrypsin, there is no reliable laboratory test for pancreatic insufficiency. Stool trypsin determination may be helpful but the absence of this enzyme in the stool is not critical for the diagnosis.) Roentgenographic evidence of chronic pulmonary disease with bronchial thickening, patchy infiltrates and hyperinflation or the presence in the sputum of certain bacterial organisms, particularly Pseudomonas species and *Staphylococcus aureus*, warrant the performance of a sweat test.

The Challenge of Treatment

Present therapy of cystic fibrosis is essentially symptomatic and can be divided into gastrointestinal, pulmonary and general therapeutic measures.

Malabsorption in cystic fibrosis is due in part to the absence of pancreatic enzymes. Commercial pancreatic enzymes from animal sources are utilized as substitution therapy (Viokase and Cotazym are examples). There is minimal difference between the preparations available. In infants, the powder is most appropriate while capsules and compressed tablets are preferred by older children. The dose is determined by titration in the individual patient up to about ten tablets or capsules per meal. In many patients, the large, foul stools improve with pancreatic supplementation and the compensatory voracious appetite decreases. Dietary management in cystic fibrosis requires primarily a caloric intake adequate to meet the patient's needs which may be increased by stool losses and coughing. Normal fat intake is well tolerated by most patients while some find that avoidance of fatty foods will reduce the volume of the stools. Vitamin supplementation in a water dispersible form is recommended in twice the usual daily dose. Vitamin K supplements may be indicated on occasion.

The basis for management of the pulmonary involvement lies in the aggressive treatment of pulmonary infections and vigorous physical therapy. Emphasis is primarily on bronchial toilet. Because mucociliary transport is unable to clear the tracheobronchial tree of these thick secretions, physical therapy and postural drainage using multiple positions is performed daily to promote drainage. The frequency is increased during periods of acute infections.

Sleeping in mist tents and inhalation of bronchodilators and/or mucolytic agents have been advocated by some investigators. Recent work, however, has shown that the amount of water actually reaching the small bronchioles is a very small percentage of that nebulized.[5] Mucolytic

agents, although helpful in a small number of patients, irritate the tracheobronchial tree leading to even more mucous secretion and further impair mucociliary transport.[6] Bronchodilators have a variable effect in children with CF.[7] In some children, they improve pulmonary function, in others they have no effect, while in still others they worsen pulmonary function. It is postulated that the reduction in smooth muscle tone in the larger airways with bronchodilator therapy leads to collapse of these airways in the presence of obstruction in the small airways. They probably should not, therefore, be used routinely.

The copious, viscid pulmonary secretions provide an environment conducive to bacterial colonization of the respiratory tract. Pseudomonas species and *Staphylococcus aureus* are the most frequent organisms. There is general agreement that appropriate and intensive antibiotic therapy is the cornerstone of the pulmonary therapeutic approach. Most patients receive antibiotic therapy only during episodes of acute respiratory illness, while some benefit from continuous antibiotic treatment with cultures at regular intervals to watch for changes in organisms and their antibiotic sensitivity. Since few diseases have such a poor correlation between physical and roentgen findings in the lungs and since it is difficult to distinguish infection from the elaboration of copious pulmonary secretions, the physician finds evaluation of antibiotic management difficult. All respiratory exacerbations should be aggressively treated with high doses of antibiotics for longer than usual periods of time.

Children with cystic fibrosis should be encouraged to participate in all forms of physical activity. Swimming and exercises that develop the musculature of the thorax are especially good. Up to date immunizations and yearly vaccination against influenza are strongly recommended.

Challenges in Understanding Cystic Fibrosis

Since the study of families having a child with cystic fibrosis has shown an incidence of the disease in one fourth of their siblings, the disease has been classified as an autosomal recessive genetic disorder. This suggests that the concept of an abnormal gene related to alteration in a single enzyme should apply. During the past few years, a large number of research observations have indicated the complexities which must be understood before any such relationship between genetic abnormality and mechanism of disease can be defined. Starting with the hypothesis that the elevated sweat salt concentration is close to the genetic defect, studies on the sweat secretory process have shown that there is a defect in reabsorption of sodium and chloride in the duct of the sweat gland.[8] Sweat from a patient with CF will produce a similar effect in the reabsorption of sodium when injected into the parotid gland ducts of the rat or perfused into the isolated sweat gland of normal man. These observations indicate that there is a substance in the sweat which interferes with electrolyte reabsorption in an otherwise normal sweat gland. Spock using rabbit tracheal ciliated epithelium, Bowman using oyster gills and, more recently, others using ciliated cells from various sources have found that serum from patients with CF will inhibit or disorganize the ciliary beat.[9,10] Serum from obligatory heterozygotes (the parents of CF patients) has the same effect with a high degree of frequency. These biological assays have not yet proven to have the reliability necessary for clinical use in identifying the heterozygote or carrier state. The ciliary-inhibiting cystic fibrosis factor appears to be a relatively small molecule (less than 10,000 molecular weight) which is bound to gamma globulin in the serum. At present, attempts to isolate and characterize this factor are underway in a number of laboratories. Its presence in the heterozygote supports its importance and potential proximity to the gene defect.

Another research approach involves the control of exocrine gland excretion by the sympathetic nervous system. The catecholamines, epinephrine and norepinephrine, for example, act upon the beta-adrenergic receptors in the secretory cells to release macromolecules such as amylase from the pancreas. Stimulation of the cholinergic receptors stimulates the secretion of ions, such as bicarbonate and water from the pancreas. It has been suggested that a further understanding of these control mechanisms in CF might help to clarify the pathophysiology of the disease.

The Challenge of Helping Patients and Their Families

The diagnosis of cystic fibrosis in childhood is an overwhelming event to the child and his family. The amount of support and education of a seemingly myriad of details concerning its management, the commitment of time and money and the need for expertise from disciplines such as physical therapy, nursing, respiratory therapy, microbiology, nutrition and social service, in

addition to experienced medical care, seem to fall beyond the immediate capacity of most family physicians or pediatricians. In 1957, the National Cystic Fibrosis Research Foundation (NCFRF), a private foundation currently named the Cystic Fibrosis Foundation (CFF), was organized by parents of CF patients and other interested medical and lay volunteers. This Foundation has as its primary purpose the promotion of care, education and research in this disease. One activity is to promote better patient care by supporting Cystic Fibrosis Centers and Clinics throughout the country where a nucleus of professionals can make their experience with CF available to all members of the medical profession as well as provide the team function of various disciplines necessary for the care of the CF patient and his family.

A group of recognized authorities in this disease visit the centers periodically to maintain standards of information, and their directors attend annual meetings at which advances in research and treatment are discussed. Support for the CFF comes from the lay chapters throughout the country. CFF supported centers in Florida are listed in Table 1.

In July 1976 a Pediatric Pulmonary Center was established at the J. Hillis Miller Center for Health Sciences of the University of Florida in Gainesville through funds obtained from the Division of Maternal and Child Health of the Department of Health, Education, and Welfare. The objectives of the Center are to establish a regional program of exemplary care for children with pulmonary diseases, and to develop an educational program to train physicians and other health professionals in the care of children with pulmonary disease using the regional approach to care. It is one of 11 such centers scattered throughout the country and serves all of Florida.

The Pediatric Pulmonary Center is staffed by experts in the areas of pediatric pulmonology, physical therapy, nursing, respiratory therapy, social work, clinical nutrition and gastroenterology, clinical psychology and laboratory technology who are using an interdisciplinary approach to the total care of pediatric patients with cystic fibrosis and other lung diseases. Through this care a comprehensive program of training of health professionals is conducted. Patient and community education are important goals of the Center. It is hoped that by regionalization of care for children with lung disease, new approaches through controlled studies can be evaluated and that children with CF and other forms of lung disease can receive the most advanced therapy available.

Table 1

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The continued vigilance, time demands for therapy, constraints resulting from episodes of illness and uncertainty in the ultimate outlook are a sustained burden borne by the parents. The prognosis has strikingly changed in the past few decades so that more that 50% of the patients live well into the second decade with an increasing number of CF patients moving into adulthood throughout the country. This shift in the outlook has proferred hope, particularly in light of the extensive research effort which may result in more specific therapy in the next decade. It is, thus, justifiable and realistic that all professionals have a hopeful and positive outlook toward this disease — an attitude of key importance in helping the CF patient and his family.

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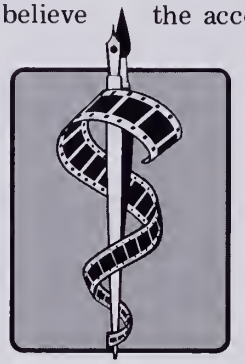
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SPECIAL ARTICLES

William Harvey Remembered

I. Leo Fishbein, M.D.

Abstract: The 400th anniversary of the birth of William Harvey, the great English medical scientist, is celebrated on April 1, 1978. His research of the circulation of the blood, "De Motu cordis et sanguinis," 1628, is the foundation of the science of cardiology.

Harvey's studies at the University of Padua with Fabricius, and his appointment to the Royal College of Physicians in England, enabled him to prove his theories through experimentation, challenging the medical beliefs of his day. This article introduces William Harvey to the student, the scholar, the doctor, and the layman; with the hope that his life and work will continue to inspire individuals to accept challenges that contribute to the public good. In honoring his memory we honor ourselves.

The scientific and medical world is honoring the 400th anniversary of the birth of William Harvey on April 1, 1978. This genius was born in Folkestone, Kent, England on April 1, 1578, the oldest of nine children of Thomas Harvey and his second wife, nee Joan Hawke. He inherited the energy, temper, and attitude for challenges from his father. From his mother came gentleness of spirit, compassion, and devoted loyalty to the Anglican Church. He enrolled in King's School, Canterbury, learning Greek and Latin. At 16, he won his first scholarship for medical studies for a period of six years at Caius College in Cambridge. Little is known of his undergraduate days at Cambridge except that he was well drilled in the classics. His favorite poet was Virgil.

His first three years at Caius related generally to medical subjects. In 1598 he became a medical student at the University of Padua, founded in 1222 as a center of learning. Still extant is this entry in Latin at Padua: "William Harvey, son of Thomas Harvey, a yoeman of Kent, of the town of Folkestone, educated at the Canterbury Grammar School, aged sixteen, was admitted a lesser pensioner at the table of scholars, on the last day of May 1593." Fabricius, the great anatomist and embryologist, was the master teacher there.

For four years he listened to Fabricius' lectures by candlelight and acknowledged his profound respect and gratitude to the master as being second to Aristotle: "In chief, of all the ancients, I follow Aristotle, and of later writers, Hieronymus Fabricius ab Aquapendente, Him as my General, and this as my Guide. I would say with Fabricius, 'Let all reasoning be silent when experience gainsays its conclusion.'" By following his teacher, he surpassed him in honor and glory!

Paduan life was scholarly and scientific. The university atmosphere was dominated by experimental inquiry. Religious tolerance, great freedom of thought, challenge, and adventure invigorated Padua's scholars. He concentrated on his medical studies. Philosophy and Aristotelian pursuits sharpened his talents. He formulated hypotheses and tested them experimentally.

Sir Thomas Barlow in 1600 described Harvey: "He was a keen and accurate observer, and an enthusiastic naturalist; and he had a mind reflective as to the causes and relations of things, fertile in recognizing resemblances; and above all, ready in making hypotheses and in devising experiments which would more or less verify those hypotheses."

Scientific Knowledge Secured in Stages

Harvey knew that scientific knowledge was secured in stages. He affirmed: "The authority of Aristotle has always such weight with me that I never think of differing from him inconsiderately." He is considered the "Christopher Columbus" of the circulation of the blood. Blood traversed closed circle from the heart of the organs and then returned. One writer stated: "William Harvey demonstrates by the structure of the heart that the blood is constantly passed through the lungs into the aorta . . .

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He demonstrates by the ligature the passage of blood from the arteries to the veins. Thus is proved a perpetual motion of the blood in a circle caused by the pulsation of the heart."

In 1602 he graduated from Padua as "Doctor of Physic" and returned to England to receive his doctorate in medicine from Cambridge. His fame had preceded him as a distinguished scholar, and he was soon prominent in medical circles. In 1604 he was admitted as a candidate of the Royal College of Physicians and became a Fellow three years later. He was elected "Censor" in 1613 and received his appointment as physician to St. Bartholomew Hospital in 1609 at the annual salary of twenty-five pounds. He served honorably in this position for 36 years. In 1615 he was appointed by the College as Lumleian lecturer with salary and duties equivalent to the Regius Professor of Physic at Oxford or Cambridge and delivered his first "visceral" lecture at the Royal College with manuscript notes in Latin and English. This was his first account of the circulation of the blood as we conceive of it today. The passage of blood from the arteries to veins was proven by means of ligatures. This was 12 years before his printed book, De Motu Cordis, was published in Frankfurt, Germany, in 1628. Both writer and publisher hoped this printing would be widely read and purchased.

In 1618 Harvey was appointed Physician Extraordinary to King James I and accompanied him through France and Spain. He later became Physician-in-Ordinary to King Charles I and traveled with him to Scotland. During the Civil War in 1642 when Charles and his entourage fled London, Harvey's home was looted and much valuable research material was lost forever. Little is known about his wife Elizabeth.

In his clinical practice, Harvey claimed to have cured cases of diabetes, dropsy, venereal disease, prolapsus uteri, hernia, and hydrocele. His mind perceived inconsistencies that had escaped his predecessors. To understand the circulation of the blood, it was necessary to observe the beating hearts of animals. "When the left ventricle stops beating or contracting, the pulsations in the arteries cease. First the auricle contracts, and this forces the abundant blood it contains . . . into the ventricle. This being filled, the heart raises itself, makes its fibers tense, contracts, and beats. By this beat, it at once ejects into the arteries the blood received from the auricle, the right ventricle sending its blood to the lungs through the vessel called vena arteriosa (pulmonary artery) . . . the left ventricle sending its blood to the aorta, and to the rest of the body through the arteries."

Harvey dared challenge the ancient thinking of Galenic dogma of ebb and flow. He told Robert Boyle how he conceived of the circulation of the blood: "Since the Blood could not well, because of the interposing Valves, be Sent by the Veins to the Limbs; it should be Sent through the Arteries, and Return through the Veins, whose Valves did not oppose its course that way." He studied the embryonic development of animals: "All animals, even those that produce their young alive, including man himself, are evolved out of the egg. There is no part of the future foetus actually in the egg, but yet the parts of it are in it potentially." He experimented with vivisection, ligation, and perfusion.

John Aubrey described Harvey as being of short stature, with "bright black eyes and raven hair, complexion like the wainscot," quick, alert, choleric, often fingering the handle of his dagger, the costume ornament of physicians. He loved to read literature by himself. Social banalities and ostentations were anathema. As an ideal English gentleman, he was most gracious and solicitous of family, friends, and servants. His sense of humor was reserved and delightful. His original discoveries caused a loss in his medical practice. He was not a strong and romantic figure even though he lived in stirring times.

Critics Riposted with Spirit

One critic stated that patients previously had been healed of their illnesses without the knowledge of the circulation of the blood; therefore, this doctrine, even if true, would be useless. The Paris Faculty issued a decree that no one was allowed to deviate from Hippocrates and Galen upon pain of excommunication. Under these auspices, medicine marched backward to the Dark Ages. Harvey's new discovery of the circulation was forbidden to be demonstrated.

Harvey riposted his critics with spirit: "The crowd of foolish scribblers is scarcely less than the swarms of flies in the height of the summer, and threatens with their crude and clumsy productions to stifle us as with smoke. No race is so savage but that, either through chance or the drive of some urgent need, it will have devised for the common weal something which has escaped the notice of other more civilized nations. Often many men, lacking in experience, get an idea of another's probable view, and later give it out boldly as definitely true. Hence it comes about that they not

only err themselves, but lead imprudent other people astray."

He knew that men, in their need to fulfill their deep ambitions for glory, cared little whom they trampled or destroyed. "Reflecting on every part of medicine, physiology, pathology . . . therapeutics; when I see how many questions can be answered, how many doubts resolved, how much obscurity illustrated, by the truth we have declared, the light we have made to shine, I see a field of such vast extent in which I might proceed so far, and expatiate so widely, that this, my tractate, would not only swell out into a volume, which was beyond my purpose, but my whole life, perchance, would not suffice for its completion."

Harvey's personal discipline protected him from the bitterness engendered in Europe. "So it has come to pass that this sheltered life and freedom from public cares has brought healing to myself . . . This life of obscurity, this vacation from public business, which causes tedium and disgust to so many, has proved a sovereign remedy to me. It is sweet not merely to toil, but even to grow weary, when the pains of discovery are amply compensated by the pleasures of discovery . . . So are the fleeting things of mortal existence made eternal through incessant change, and kinds and species are perpetuated though individuals die."

His courageous character was decisive. "The truth is more beautiful than the evening and morning stars . . . This book of mine was the only one to oppose tradition, and to assert that the blood travelled along a previously unrecognized circular pathway of its own . . . I propose to learn and teach anatomy not from books but from dissections, not from the tenets of Philosophers, but from the fabric of Nature. Nature is nowhere wont to reveal her innermost secrets more openly than where she shows faint traces of herself away from the beaten track."

One of the first records of the experimental approach to pathology was shown by Harvey's insatiable curiosity: "I have myself, for experiment's sake, occasionally pricked my hand with a clean needle, and then having rubbed the same needle on the teeth of a spider, I have pricked my hand in another place . . . The part pricked with the envenomed needle immediately contracted into a tubercle, and by and by became red and hot and inflamed, as if it collected and girded itself for a contest with the poison for its overthrow." . . . "The heart . . . is the beginning of life; the sun of the microcosm, even as the sun in his turn might well be designated as the heart of the world; for it is the heart by whose virtue and pulse the blood is moved, perfected, made apt to nourish, and is preserved from corruption and coagulation; it is the household divinity which, discharging its function, nourishes, cherishes, quickens the whole body, and is, indeed, the foundation of life, the source of all action."

In 1653 the Harveian Library was donated to the College of Physicians that honored him with its presidency. He gave his estate of Barmash, Essex, with the provision for an "annual feast at which a Latin oration should be spoken, to commemorate the benefactors of the College, to exhort the Fellows to study and search out the secrets of nature by way of experiment; and also for the honour of the profession, to continue in love and affection among themselves." He paid for the library building and furnished it with books on astronomy, geometry, geography, music, optics, natural history, travel, and medicine.

"Little Doctor Harvey" died June 3, 1657, at 79, ten months short of his 80th birthday. He was buried in Hempstead, Essex. His will, in his own handwriting, had been written five years earlier, including individual bequests to his and his wife's families, and to servants, friends, and the College. The stone beneath his bust read: "William Harvey, at the mention of whose honourable name all academies rise up out of respect, who was the first after many thousand years to discover the circulation of the blood, and so brought health and immortality to himself." A great funereal procession was held in London on June 26, 1657.

William Harvey has been one of the master builders of mankind for he has left a legacy to humanity. His star of achievement will shine whenever and wherever men of learning gather recounting the enrichment of their heritage. He aspired and he inspired. He challenged and overcame every obstacle of ignorance and superstition, promoting the love of truth and the love of his genius.

Dr. Chauvois avowed: "The more we read William Harvey and penetrated into his mind, the greater his figure seems to loom up through the ages. . . . He is, without a shadow of doubt, among the three or four master intelligences of all time."

I am appreciative of the kind assistance by the librarians and staffs of the University of Miami Louis Calder Memorial Medical Library, Miami-Dade Community College, North; Mt. Sinai Medical Center of Miami Beach, as well as the Miami and Miami Beach Public Libraries.

References and reprints are available from the author upon request.

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William Harvey

Michael B. Brodin, M.D.

April 1, 1978 marks the quartercentenary of the birth of William Harvey. His life and work deserve to be reviewed periodically because of his exemplary qualities as a physician and humanitarian.

Harvey is remembered primarily for two accomplishments, one of which is far better known than the other. The more prominent is his discovery of the circulation or, more precisely, scientific proof that the blood circulates. The other is his demonstration of epigenesis in embryology, that the organism is not preformed in the egg but rather develops as a result of the action of the environment on the protoplasm.

We can picture him from a description given by Aubrey as quoted by Robinson:

"He was not tall; but of the lowest stature, round faced, olivaster complexion; little eie, round, very black, full of spirit; his haire was black as a raven, but quite white 20 yeares before he dyed."[1]

The same author allows us to catch a glimpse of his character, a character which obviously would not allow him to shy away from the controversy he was to create:

"He was, as all the rest of the brothers, very cholerique; and in his young days wore a dagger . . . but this Dr. would be apt to draw out his dagger upon every slight occasion."[1]

He did practice medicine but, in the spirit of the true researcher, did not devote himself entirely to it. His ambition was clearly not to be a successful practitioner but only to be a successful observer of nature.

If a word could suffice to tell us Harvey's secret it would undoubtedly be "perseverence." He states, for example, that his initial investigations into the nature of the circulatory system were so beset by difficulties that he was tempted to think, as did Fracastorius, that the motion of the heart could be comprehended only by God!

But his nature would not let him give up and his numerous observations took the form of copious notebooks. By scientific experimentation and deductive reasoning he became aware of the fallacy of the Galenic teachings. These theories held that the liver was the source of the blood, of which there were two kinds, arterial and venous, both in perpetual motion but the only communicating point being at the ventricular septum.

The first public announcement of the new theory of the circulation was on April 17, 1616, at the second Lumlein lecture of the season. It seems not to have created an enormous stir in the medical community at large but there are at least two good reasons for this. Firstly, the contents of a lecture are rarely publicized widely. Secondly, these lectures were given in Latin, with English sprinkled only here and there to make a point. There were probably many "more who heard than who comprehended."

Harvey says of this experience:

"These views as usual pleased some more, others less; some chid and calumniated me, and laid it to me as a crime that I had dared to depart from the precepts and opinions of all anatomists; others desired further explanation of the novelties."[2]

As was the case with Darwin and Copernicus, he also delayed publication of his theory. His reasons for this we can only guess. Copernicus dreaded the prejudices of mankind, it is said, and rightly so. Darwin wanted to perfect his work. Harvey waited for twelve years, until 1628, and then had published in Germany a poorly printed book of seventy-two pages, entirely in Latin, full of typographical errors with paper that foxed easily. Its full title, **Exercitatio anatomica de motu cordis et sanguinis in animalibus**, being somewhat formidable, is usually shortened to De Motu Cordis.

Times have changed. Observe the introduction to this work:

TO THE MOST
ILLUSTRIOUS AND INVINCIBLE MONARCH,
CHARLES,
KING OF GREAT BRITAIN, FRANCE
AND IRELAND,
DEFENDER OF THE FAITH

Most gracious King,

Who would dream, today, of producing that sort of verbiage to introduce a scientific work, no matter how controversial the subject.

In the 8th Chapter, he tells us that he predicts some "rattling of shutters":

"What remains to be said upon the quantity and source of the blood which thus passes is of so novel

and unheard-of character, but I not only fear injury to myself from the envy of a few, but I tremble lest I have mankind at large for my enemies, so much doth want and custom, that become as another nature, and doctrine once sown and that hath struck deep root, and respect for antiquity influence all men: Still the die is cast, and my trust is in my love of truth, and the candour that inheres in cultivated minds,"[3]

The book is a masterpiece of scientific reasoning and was the culmination of painstaking investigation which included numerous dissections. But the crux of the work was something which before that time had not been placed in a medical treatise and which was so irrefutable that any right minded medical man of the day could not help but see the truth. Harvey proved, simply, that **mathematically** it was impossible for the blood in the body to do anything other than circulate. By calculating the volume ejected during systole and multiplying by the heart rate he demonstrated that the blood had to be returned to the heart:

"Let us assume, either arbitrarily or from experiment, the quantity of blood which the left ventricle of the heart will contain when distended, to be, say, two ounces, three ounces, or one ounce and a half . . . Let us assume further how much less the heart will hold in the contracted than in the dilated state; and how much blood it will project into the aorta upon each contraction . . . and let us suppose as approaching the truth that the fourth, or fifth, or sixth, or even but the eighth part of its charge is thrown into the artery at each contraction; this would give either half an ounce, or three drachms, or one drachm of blood as propelled by the heart at each pulse into the aorta . . . Now in the course of half an hour, the heart will have made more than one thousand beats . . . Multiplying the number of drachms propelled by the number of pulses, we shall have either one thousand half ounces, or one thousand times three drachms, or a like proportional quantity of blood, according to the amount which we assume is propelled with each stroke of the heart . . . a larger quantity in every case than is contained in the whole body!"[3]

With one book he had placed medicine in general, and physiology in particular, firmly in the realm of science. Once a study becomes based on mathematical principles it achieves a certain respectability.

We return to Aubrey for his knowledge of the reception of De Motu Cordis:

"I have heard him say, that after his booke of the Circulation of the Blood came out, that he fell mightily in his practize, and that 'twas beleeved by the vulgar that he was crack-brained; and all the physitians were against his opinion, and envyed him; many wrote against him . . ."[1]

Many similar situations can, of course, be drawn throughout history. Copernicus, and Darwin again; Galileo, Lister, Pasteur and so on. It is a peculiar human trait, this conservative rigidity which prevents men from accepting new ideas. Yet there is obviously a beneficial side to it as well and many forms of quackery are thereby prevented from being introduced into the world before they can produce irreparable harm. As scientists, our problem has always been to judge the new ideas and theories that are constantly being presented to us. We must be careful not to let ourselves become so complacent that we reject the new simply because it is new or fail to accept change because it is change. We do the best that we can with the knowledge present in the state of the art and hope that we do not let our prejudices cloud our logic. If there be a way to increase the number of times we accept the good and reject the bad we should implement that system.

There is, however, another, more healthy way of viewing the controversy provoked by novel scientific work. Oliver Wendell Holmes, whose "The Contagiousness of Puerperal Fever" excited much obstetric hostility in 1843 said: "Every real thought on every real subject knocks the wind out of somebody or other. As soon as his breath comes back, he very probably begins to expend it in hard words."[4]

There is some controversy, even today, concerning the primacy of Harvey's discovery. It is said that he was not the first to conceive of the possibility of the blood being returned to the heart, that many others had the same suspicion. But it is one thing to theorize and quite another to prove and there can be no controversy that Harvey demonstrated his ideas so effectively that he lived to see his theory accepted as fact in his lifetime. One of the very few to see this happen.

His life after the publication of De Motu Cordis consists of an interesting but somewhat tragic series of events which involved him in the political intrigues then occurring in England. He was caught on the royalist side of the dispute between King Charles and Oliver Cromwell and it can rightly be said that his contributions to science would have been far greater had not his voluminous notes been destroyed by the Parlimentarian forces during one of their forays of revenge.

We can be sure that after the resolution of this

conflict much of his fighting spirit dissipated and he retired to some serene contemplation of animal embryology. As always, however, this contemplation led to experimental work and the work led to a large number of notebooks, but so desirous was he of avoiding controversy that he had to be convinced by a friend, Sir George Ent, to publish this work. Dr. Ent gives the following as Harvey's reply when asked why he had not attempted to have the book published:

"And would you be the man who should recommend to me to quit the peaceful haven where I now pass my life, and launch again upon the sea? Much better it is oftentimes to grow wise at home and in private, than by publishing what you have amassed with infinite labor, to stir up tempests that may rob you of peace and quiet for the rest of your days."[5]

Ent, however, convinced him otherwise and was instrumental in having this larger treatise published in 1651. **Exercitationes de Generatione Animaium** was a larger book than its predecessor, 568 pages, but was less of a well ordered study of a physiological phenomenon, yet, it is a brilliant study and one full of novel insights and corrections of erroneous ideas. It would be considered great by any measure but because of the superiority of De Motu Cordis it has been somewhat eclipsed with time.

Thus, it was that at 73 Harvey saw the publication of his last work and was finally able to embark upon a rest from his labors. In examining a life, S. Weir Mitchell supposedly said, the first thing a biographer ought to do is to examine the stubs of the victim's check book. Prior to retirement, however, it is likely that Harvey did not write many checks himself, as his financial affairs were handled (very successfully it must be said) by his brothers. He himself was not known as a good businessman. Even so, at the age of 73, Harvey found himself to be rather wealthy. The disposition he made of this wealth is self-explanatory.

He donated money to build an annex to the College of Physicians that would be used as a library and meeting hall; he donated money for the books and donated books from his own library as well; he even provided for the salary of the librarian. He gave the College an estate that he had inherited from his father. Most notably he endowed an annual lecture, the Harvein Oration, which is today still delivered each St. Luke's Day.

Harvey, by even the most critical reckoning, stands as the most illustrious physician of the seventeenth century. His worth is due to inspiration as much as it is due to the inherent nature of his scientific discovery. His work constitutes a major portion of the foundation upon which rest the accomplishments of modern physiology.

Sir William Osler paid tribute in his Harvein Oration in 1904 by reminding his listeners that the sponsor of these talks had donated the money "to commemorate on this occasion by name all our benefactors; to urge others to follow their example; to exhort the Fellows and Members to study out the secrets of Nature by way of experiment; and lastly, for the honor of the profession, to continue in love and affection among ourselves. No greater tribute to Harvey exists than in these simple sentences in which he established this lectureship, breathing as they do the very spirit of the man, and revealing to us his heart of hearts."[2]

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The past is never dead, it is not even past. — William Faulkner

On Altruism

Lewis Thomas, M.D.

The phenomenon of altruism in biology has been argued over with such intensity of feeling that the very idea has lost much of its amiable aspect, and instead of being a newly recognized, rather delightful fact of life to be reflected on in puzzlement it has become the topic of an intermittently ill-tempered doctrinal dispute among professionals over how nature, in general, works. It is at the center of today's bitter arguments over the issue of Sociobiology.

There are now two sides, both ideological. They are in agreement that there is such a thing as altruism, and part of the argument concerns how much, and how generally it is distributed. One side says that it is narrowly restricted to a few freakish species of lower forms, most notably the colony ants and bees, and in these creatures it has no relevance at all to the superficially similar altruistic behavior of human beings. The distinction is crucial to this side's argument. In ants the helpful, self-abnegating behavior is no doubt coded by genes, but in humans this kind of social behavior, or for that matter any kind, has to be determined by society itself, by culture; it does not come naturally, in this view, and it has nothing to do with genes, and whether displayed by individual people or by groups it can only be learned from the rules of the group.

The other side asserts that there is indeed a connection between the stereotyped behavior of insects and the less predictable, more happenstance altruism of higher animals, including ourselves, but there have to be genetic explanations for behavior of this kind whenever it occurs. One explanation meeting the needs of evolutionary doctrine is that altruism is a good way of preserving genes. Insects behave as they do because the self-sacrifice of an individual in aid of his close relatives automatically assures the survival of large collections of his own genes, or sets of genes closely similar to his own. This way of looking at success in evolution assesses the survival of genes rather than individuals. Any trait that tends to keep up the total complement of genes within a kinship, by favoring the survival of the group, would be correspondingly favored by natural selection.

It is both a technical and ideological argument, and my chief objection is that both sides are taking all the fun out of altruism. One side says it doesn't really exist as a manifestation of nature and can only be learned by indoctrinated people who live in an unusually instructive society, while the other side says it does exist but is a fundamentally selfish and combative mechanism designed to give one family of genes a survival advantage over competitors. Both sides seem to me to have narrowed the discussion down too closely.

The term altruism, as used in these discussions, is restricted to the sacrifice of one individual's life for the sake of others of his own kin, and this is a narrow definition indeed. I would prefer to broaden it here to include all behavior which can be interpreted as indicating good will, or helpfulness, or friendliness, or what we would all accept, to coin a phrase, as good nature. There is a lot more of this in the world than we used to believe, and much less evidence for the kind of incessant, compulsive infighting that used to be regarded as the sole pre-occupation of nature.

It is almost safe to assert, on scientific grounds, that altruism would have to exist as a general principle, if a system so dense and at the same time so immense, containing such a flabbergasting variety of coexisting forms of life, were to have any sort of permanent existence as the life of the earth, as it plainly does. If all the components were continually locked in combat, red in tooth and claw, struggling to edge each other off the planet, bent on survival by extermination, the place would be a shambles, and it is not.

Different Way of Looking at Evolution

I suggest a different way of looking at evolution. Up until now biology has focused attention on the factors involved in the evolution of species, or of the individuals contained within species, and in

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recent years on the evolution of proteins and other macromolecules inside the individuals. We need now to be examining more closely the evolution of the whole system of living things, the entire, spectacularly coherent structure of the biosphere. There is something like musical counterpoint in this massive arrangement, and we are all aware of the complex harmony. It works, it has always worked, it has a life of its own, and it is as beautiful as a beetle. We don't need color photographs taken from the moon to be persuaded of this; we know it in the frontmost part of our minds.

I am not thinking here of the nonorganic influences on the development of life, such as the weather or solar radiation or the drifting of continents. What I mean is the influence of all the life, collectively, on the separate parts of life.

This is what we are really talking about when we use the term environment. When any new version of animal, or plant, or whatever, is tested for its capacity to adapt to the environment, in candidacy for evolution, the grades scored are based on how well it makes out with the other living things around.

And now that the whole system has become filled with life so that there are no longer any lifeless places on the planet, there is an infinite number of organisms to fit with. Viewed from a little way off, the mass of life seems to get along by functional linkages among all the individual forms. It operates this way, like a coral reef or a rain forest, a handful of loam, or a motorcycle. Each part is dependent on all the other parts. There are no solitary, isolated parts, no unused or useless bits. The main business is the trapping of energy by some of the parts for feeding, the recycling of food to provide new sources of energy for other parts, and the storing up of energy in the form of information. By this time, after 3 billion or so years of work, the volume and complexity of the information now locked into the system, most of it contained in membranes, is beyond comprehension.

It is not true that evolution has proceeded as a totally random process, unrestrained by any general law. There is, I think, a law of sorts, or at least a rule of thumb. It is that life on this planet is interconnected, and anything new that comes along has to accommodate itself to the whole system.

Any new creature or any novel form of an existing creature cannot just walk onto the scene and take over, ignoring the rest of life. In order to make it, he has to arrive already equipped with an abundance of hard information about the marks of others plus some precise instruments for sensing and communicating. He must have things to give away, and must know how and where to leave them so they can be picked up. If he is to receive in return the things he needs, the feel of the these must already be familiar to him. He requires membranes to do these things, and a long memory.

An Opaque Obstacle

The system is there to look at but there is an opaque obstacle that keeps blocking our view of it, preventing us from taking it in. The obstacle is us. We have become so conspicuous that we are in our own light. We seem to have swarmed over everything, elbowed our way into every hidden place, taken over. By every appearance we now look like the most dominant being that ever lived, in total control of the whole operation, and since we know as a deep truth that this cannot be so it is embarrassing.

We are in need of a better understanding of the role of self-marking in the social arrangements that have enabled the various forms of life on the earth to emerge together in their evolution, and cohere. The tendency to join up, to cooperate, is probably one of the most ancient features of our kind of life, antedating and perhaps even setting the stage for most of the crucial events in evolution. The earliest organisms were undoubtedly prokaryotes, much like today's bacteria. Somehow or other nucleated cells developed from these early cells; one credible speculation has it that this could have happened as the result of fusion of two or more different types of non-nucleated cell. Certain prokaryotes also took up their existence as organelles inside the earliest nucleated cell. The mitochondria in our own cells, according to this view, are the direct descendants of bacteria engulfed by the first eukaryotes, and the chloroplasts of plants are symbionts descended from blue-green algae. They are not really our creations; they are lodgers on whom we have become totally dependent for all our energy. Between them, the chloroplasts which tap the energy of the sun, and the mitochondria which tap the energy stored by the chloroplasts, are in charge of the life of this planet.

It is quite possible, even likely, that the earliest forms of multicellular life on the line leading to the emergence of all metazoans including roses, dolphins and ourselves, were the result of the joining up of separate, free-living single eukaryotic cells in symbiosis, long, long ago.

If these things are true—and if that is the way prokaryotes grew into eukaryotes and eukaryotes

into humans—it must have been a highly specific and meticulously regulated event. If there was, in the early days, a universal tendency to join up—with selective value associated with successful fusion and collaboration—it could not have occurred in a random unregulated way, or we would have ended up as a diffuse, featureless syncytium covering the earth's surface, a considerably less interesting outcome than what we have around us today. There had to be markers for the recognition of the right sorts of partners, not so much self-markers as specific, correct other-markers.

Invasion of one's tissues by bacteria—even the taking over of whole tissues and organs by bacteria—is not necessarily a catastrophe in nature. There are a great many animals, including most spectacularly the cockroach, which are unable to live without the colonies of specialized bacteria living in their tissues; if you get rid of the bacteria by treating the cockroach with antibiotics, you kill off the whole insect as well. The rhizobial bacteria are the most violently invasive of microbes; they swarm into the root hairs of leguminous plants like beans and soybeans—they colonize all the space they can get and simply take over, but it is not a disease in any sense of the term, it is simply nitrogen-fixation for the planet.

I do not believe that these conspicuous examples of symbiotic living are biological freaks. They are not exceptions to the rule, they are the very declarations and assertions of the rule. The stupendous structure we call nature is held together in this way, it depends for its long survival on the collaborations worked out among its numberless working parts; it needs individual selves, and individual species, so that the parts can recognize each other and establish partnerships that will work. This is the way the place has evolved, this is the way the world goes, it works this way. It is by no means a perfect world; accidents occur, and things get dropped, or we would not have rabies, virus, or tuberculosis, or catch colds. But on balance, considering all the things that could go wrong, it works marvelously well. We should, I think, be learning more about this side of nature, for our safety and survival as a species as well as for our pleasure in beholding it.

▶ Dr. Thomas, 1275 York Avenue, New York 10021.

Board of Medical Examiners Needs Address Change Notice

The State Board of Medical Examiners reports that several hundred annual registration licenses are undeliverable because of incorrect mailing addresses.

The Board asks that any Florida-licensed physician who has changed mailing addresses within the last six months advise it of the new address. The Board's address is Suite 220, Oakland Building, 2009 Apalachee Parkway, Tallahassee, Fla. 32301, telephone (904) 488-7614.

The Need for Improvement of the Public Health Program in Florida

Robert E. Windom, M.D.

Historically, one may review the success of the public health program in Florida through 1968 when a significant change occurred that has resulted in the development of a newer program which has been less efficient and consequently less successful in its efforts. At one time Florida was a model throughout the country because of its excellence in providing a statewide coordinated effort with a public health department under the direction of a capable physician in leadership capacity. The lack of physician direction and the present fragmentation of the program has found Florida to be virtually on the bottom of the totem pole throughout the 50 states as far as providing an effective program. This is exemplified also by the state spending practically the lowest per capita dollar of state funds for the public health program.

Like any profession or business, the people most knowledgeable in that particular discipline are those who are "on the inside." No one has more knowledge or insight into the needs than the individual who has been fully trained and has the expertise of his particular area. When it comes to mounting a statewide program, no one would doubt the value of the direction being provided by a person most knowledgeable in the particular field involved. For Florida to re-establish its strength in the public health field, it is imperative that a program of continuity be established throughout each county health office under the same direction of a competent physician with authority to direct active programs and to react promptly to problems that arise. A mechanism for accomplishing this task can be done in two ways. One, **a separate Department of Health** under the direction of a physician. Secondly, the ideal mechanism would be for a physician to serve as a cabinet officer within our state government which would place the area of health on a level equal to that of the other cabinet positions which serve special needs of our citizens.

Today we all look at the area of health differently than we did just a few years ago. The future indicates that government on all levels will be more involved with health care. Let us not wander along the way and not take advantage of the mistakes that have been made in the past. We should not allow a health program to exist that is inefficient and unduly expensive. Medicine as a discipline has established over many years a cherished position in the minds of everybody because of one's own selfish desire to live a long and healthy life. The many years of training and experience necessary to become a physician have served as a mechanism to prevent virtually all but the most competent to go into this lifetime profession. Therefore, such an individual is unique in his ability to understand the myriad of health problems affecting the public and how best to deliver health services. Granted, we have seen a multitude of people from all other walks of life enter into the health program on various governmental levels with the assumption that they have all the answers. Just by looking at the monumental costs of the Medicare and Medicaid program and to see so many deficiencies indicates that many of these quasi-medical people are not very knowledgeable to solve complex medical problems.

Various diseases still occur in sporadic outbreaks throughout our country that require immediate action by health care providers. Also many chronic diseases continue to demand statewide attention. Having direct leadership by a physician over the state program would allow the citizens of Florida to receive the maximal benefit from our own public health service. To illustrate, just this past year an example of a national influenza immunization program was implemented and within our own state weeks went by and still there was no direct coordination of leadership or advice to be given to the local communities, simply because our present governmental structure does not have what we are seeking.

Let me illustrate another example of where our present program lacks direction. This concerns the disease of rheumatic fever and its consequences of

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rheumatic heart disease. Four years ago it was grossly apparent that there was no effective mechanism to help eradicate this disease or to maintain an effective program of prevention. A Task Force was formulated consisting of three representatives from the Department of HRS, Florida Medical Association, and the American Heart Association, Florida Affiliate. This embodied three separate disciplines relating to this disease, uniting together to tackle the problem most effectively. Medical leadership has directed this Task Force along with the advice of those most knowledgeable in the field who were not physicians. It has taken us four years to reach the point where we now have funding as a result of action by our state legislature which responded to our presentation for the vital need of financial support. We have made inroads very slowly because of many and varied obstructions that we have met through the present health structure in our state. Our goals are far from met but we feel that we are making progress toward them. This disease can be eradicated, it can prevent untoward expense as a result of its eradication, and hundreds of our Florida citizens can be productive who otherwise would be disabled and dependent upon state support if the disease continues. If we had the public health program in Florida that we desire, this program could have been implemented and operating much earlier. Also, this is just one of many instances where an efficiently operated program on all levels of health care can save millions of dollars in the long run, albeit that a significant expenditure must be made to implement the program.

Please be assured that the Florida Medical Association has but one interest in presenting our recommendations to you. No group is more vitally concerned with the health and welfare of the citizens of Florida. However, no group has been scrutinized more critically than the medical profession by those outside of its walls. We proudly accept just criticism; however, we strongly defend our profession when it is unjustly criticized and placed on a pedestal to be scorned by individuals or groups whose sole purpose is to destroy the quality and excellence of the medical profession. We respect our historical position in society and wish to maintain the integrity inherent in those most capable of delivering health services. In order for the generations of the future to have members dedicated to serve as physicians, we must do everything possible to maintain the high standards of the profession. To allow our state government to maintain less than an ideal public health program would be a disservice to Florida citizens as well as to our profession. I feel confident that any other profession or any specific business would share our philosophy and equally demand its just participation in whatever endeavor the state took relating to it.

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All ages have said and repeated that one should strive to know one's self. This is a strange demand which no one up to now has measured up to and, strictly considered, no one should. With all his study and effort, man is directed to what is outside, to the world about him, and he is kept busy coming to know this and to master it to the extent that his purposes require .... How can you come to know yourself? Never by thinking, always by doing. Try to do your duty, and you'll know right away what you amount to. And what is your duty? Whatever the day calls for.

—Goethe

What Is Needed in Family Practice Teaching Today

A Concept

James J. DeVito, M.D., ABFP

The resident is trained in family practice, a relatively new specialty. Traditionalists, however, still adhere to the term — and philosophy — of general practice, and some physicians today have been teaching this special interest for more than 25 years — a fact that may startle more recent genuine and reverent teachers.

In its incipiency general practice training involved an apprenticeship, a term now refined into internship, preceptorship, residency. Initially it was a way medicine could be learned. The preceptor received instruction in a medical center. He passed along the knowledge to his colleagues and to the young physician who was his student. This is the keystone upon which founders of the American Academy of General Practice based their entire concept. They envisioned general practice as most needed and deserve considerable credit for their perseverance and fortitude in bringing about recognition of the general practitioner as a specialist in family problems.

Family practice training programs are producing physicians well trained in medicine, pediatrics, family planning, counseling, and the controversial discipline, behavioral science. Priorities, however, need to be evaluated and direction chosen in planning these neonatal programs — neonatal because they are indeed newborn in the eyes of other specialties. Physicians should determine the emphases then inculcate a philosophy of learning and clinical experience which ultimately will produce the type of practitioner needed and desired.

Diagnosis, treatment and prevention are important and not so much resolution of all the psychological problems of a mature and educated public. The people have been analyzed to fragments by modern innovations. Never have so many agencies worked so hard to try to solve so many mental and social problems. Paramedical and nonmedical, pseudo-trained and government-hired personnel have invaded the intimacy of home and family and even influenced medical institutions to employ contrivances aimed at diagnosing and interpreting all aspects of behavior — geneology, aptitudes, preferences, likes, dislikes, inclinations and propensities — to the point that spontaneity has been sapped away. We have forgotten that individuality is an intrinsic element of human nature and that simply to be human does not imply a myriad of personality traits or imperfections.

Training programs as presently structured are good as a beginning, but the opinions and thoughts of residents and students should be heeded. Schedules and curricula should have this representation. We as mentors must tune our instincts to what the person of the resident or student is saying and hear his spoken desires and suggestions.

Many residents feel they are being overdosed with behavioral science which may fail to consider the whole person physically and psychologically; yet are inadequately trained in surgery, urology and orthopedics. They understand the need to be facile in office gynecology, urology, and therapeutics but feel there has been neglect in their training in these areas. They recognize the necessity for basic pediatrics, medicine, endocrinology, pulmonary medicine, and hospital care; yet they need to be familiar with the more difficult cases: how to bridge the anion gap in metabolic acidosis, alkalosis, blood gas analyses, and respiratory acidosis. More time in the emergency room would permit them to experience the subtle nature of early disease.

Training programs should not be top-heavy with scientific behavioral science clinics. This is the domain of the specialist. Programs should be more concerned with the aspects of human endeavor and living that many elder practitioners know and use every day without specifically designating it as behavioral science. The best way to learn how to be a doctor is to do what a doctor does. This should provide the necessary background in behavioral science.

Dr. DeVito was former Associate Director of St. Vincent's Medical Center Family Practice Program in Jacksonville and Chief of Medicine at the St. Augustine General Hospital in St. Augustine. He is presently in Rural Family Practice in Hailey, Idaho.

An occasional program has taken the effort to be thorough. This has come to pass most successfully in one small community hospital used as the base for a family practice program. The residents have an unusual esprit d'corps. They are eager and apparently involved in all aspects of the program. They are permitted to diagnose disease conditions and admit patients to their own wing. They institute orders and control the case. This is done under tutorage of the professional staff but with a more or less hands-off policy as long as residents are doing a good job. The hospital has a noticeable representation on its staff from the family practice specialists.

There is a phase of the training program which should be considered seriously. That is the possibility of developing special interests and actually augmenting training along special interest lines to enable the young physician to become a member of a specialty society. This has been accomplished by additional experience and training in obstetrics, gynecology and selective divisions of internal medicine such as endocrinology, allergy, cardiology, and rheumatology. There is no reason why the family practice resident, who feels particularly facile in certain areas of medicine, cannot develop his expertise along these lines to the point of becoming a participating member of a specialty society or organization. This can be an exciting potential outlook for the resident and prevent him from feeling that there is a part of medicine in which he cannot qualify as an expert. The final product — a polished, well-rounded, well-trained young physician — would not be diluted within the scope of his training. The resident would be prepared when he stepped into the area he wished to serve.

It behooves us to instill in young physicians the feeling of confidence in their ability to handle 85% of their patients' ills and to know when other help is needed, who the best specialists are, and then work with them to follow through the complete treatment. The resident should be prepared to assist with surgery on his patients and observe pathology in vivo, know what is done, how it is done, and be satisfied to have been a part of it. The patient derives confidence from knowing his doctor was there helping with the problem, aware of probable complications and prepared to continue later care.

Debate is likely to continue regarding the structure of the family practice training curricula. Whatever the outcome, efforts should be directed at producing a physician in the finest sense of the word. Didactic and ethereal rumination into the complex patterns of patients has a minor place in these programs. Such pursuits belong more to the academician.

All the motivation of the family practice resident must be transposed into the concept — DO. Much knowledge in medicine is through interviewing, coming to know the patients. This is doctoring and the trend should be more in this direction, not toward just practicing medicine.

Acknowledgement

I would like to give credit to these wonderful people for their help in preparing this paper: Mrs. Rae DeVito, Mrs. Martha Moore, Marshall Brainard, Executive Secretary, Florida Academy of Family Practice, and Jane A. Ackart, A.R.T., Medical Records Administrator, St. Augustine General Hospital.

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New ideas cannot be administered successfully by men with old ideas, For the first essential of doing a job well is the wish to see the job done at all. — Franklin D. Roosevelt

Disclosure of Medicare Payments Data

Richard C. Clay, M.D.

Remember the big flap last year when the Department of HEW released 2200 names of physicians and other suppliers who had received $100,000 or more from Medicare during the preceding year? You probably also know that there was an extremely high percentage of inaccuracies for which Secretary Califano ultimately apologized. But that was only a temporary setback in HEW's continuing effort to make such data public.

Under the "Government in The Sunshine Act" (P.L. 94-409), the Medicare Bureau **requires** all **Medicare Part B** carriers **once a year** to prepare a list of suppliers, physicians included, listing with each name the amount of assigned **benefits** paid to the doctor directly and the amount of unassigned **benefits** paid to the beneficiaries on the basis of claims submitted for services rendered by him. Each physician will receive from the carrier no later than February 1, 1978 this information as supplied by the carrier's files for 1977. The physician **then** will have 30 days to respond if he wishes to dispute the information. The carrier will **thereafter** review its data, make alterations if errors are found, and , if not, simply notify the physician that the amounts listed were correct.

By April 30, 1978 a final list of physicians, together with amounts of assigned and unassigned **benefits** paid by the carrier during 1977, will have been completed and **made available** for public inspection at the carrier's offices and at each branch or field office over the state.

You will remember that the Directors of Florida Blue Shield interpreted the HEW request for **profile** data last year as less than mandatory and refused to furnish the information. Now, however, Blue Shield will be required to comply **with this request for payment data disclosure.**

Interestingly, the Blue Shield Association is about the only organization which has protested this new set of regulations. This it did in an October 11, 1977 letter to Senator Talmadge, Chairman of the Subcommittee on Health of the Finance Committee of the Senate. So far as can be determined, organized medicine has not protested **as yet.**

It is the purpose of this summary to put the members of the Florida Medical Association on notice that Blue Shield of Florida as a Medicare **Part B** carrier is being required to release this information by directives from the Medicare Bureau and against the wishes of the Corporation's directors. Don't be surprised and don't blame Blue Shield when this information becomes public on April 30.

Dr. Clay is Chairman of the Professional Relations Committee of Blue Shield of Florida, Inc.

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WANTED: More to improve, fewer to disapprove; more "doers," fewer "talkers." More to say "it can be done," fewer to say "it can't be done." More to inspire others with confidence, fewer to throw cold water on anyone taking even one step in the right direction. More to get into the thick of things and "do something about it," fewer to sit on the sidelines merely finding fault. More to point out what's right, fewer to keep harping on what's wrong. More to "light a candle," fewer to "curse the darkness."

The Diabetes Centers Act

Yank D. Coble Jr., M.D.

In 1976 the Florida Legislature passed a bill relating to diabetes mellitus (Florida Statute 241.753). Because of the potential benefits of this act to patients and their families, to the medical centers, and to the physicians of Florida, and because of some potential difficulties created by this act, a review of the act and developments related to it seem appropriate at this time.

Diabetes Centers Designated: This act created "diabetes centers" for education, treatment, and research to be located at each of the three medical schools in the State of Florida. The programs of the centers are to be administered by the medical schools in consultation with the Secretary of Health and Rehabilitative Services. Specific duties of the centers include: (1) responsibility for training (including health professionals, patients, relatives of patients and the public); (2) treatment of referred and non-referred patients including specifically but not limited to indigent patients; (3) research; and (4) consultation and support for county health departments.

Advisory Council Created: In addition, this act created a Diabetes Advisory Council composed of 15 citizens of the State to advise and consult with the Deans of the Medical Schools and the Secretary of Health and Rehabilitative Services (HRS) in developing overall policy and procedures to establish a statewide health care delivery system for diabetes mellitus. Council members were appointed by the Governor from nominations by the Board of Regents, the Board of Trustees of the University of Miami, and the Secretary of HRS. By law, composition of the Council includes four physicians, one representative from each medical school, seven interested citizens (at least three of whom must have diabetes or have a child with diabetes) and one representative of HRS.

Funds not Appropriated: Despite the broad responsibilities created by this act, neither the diabetes centers nor the Council were provided funds to fulfill their legislated responsibilities. In fact, general revenue funds are specifically forbidden and total costs related to the act are to be paid from grants, donations, and funds for services. The source of these grants, donations and funds for services is, of course, unspecified by the act. While the supporters of this particular legislation may take credit for concern for diabetic patients, they are not burdened with the potentially unpopular position of appropriating funds for fulfilling the designated responsibilities.

In the past there has been concern expressed regarding "disease oriented" or "categorical" legislation in the health field. The risk of such legislation is readily apparent in the present situation; the carefully formulated priorities and ongoing programs of the medical centers could be disrupted by the necessity to move funding to the newly legislated but unfunded areas of responsibility.

In October of 1977, the Deans of the University of Florida and the University of South Florida Medical Schools and the representative of the Dean of the University of Miami School of Medicine considered the act with the Board of Governors of the Florida Medical Association. They agreed "that the Florida Medical Association support the work of the Florida Diabetes Advisory Council in securing funds to determine the present resources for education, research and training in diabetes, and to identify Florida's needs relating to diabetes" (Board Motion 77-10-83). Such a study should provide sufficient information to indicate what level of legislative support is necessary for the medical centers and HRS to fulfill their responsibilities under the diabetes centers act.

The Council has met with legislators and legislative committees to inform them of the activities of the Council as well as the needs of the centers and HRS. Further, the Council has requested that the Florida Statute be amended to permit the use of general revenue funds.

What does this mean to the physicians of Florida? The development of diabetes centers of excellence at the medical schools should provide ready and accessible consultation sources, assistance in the management of difficult patients, and centers for continuing education. The citizens of Florida cannot help but benefit from the proper development of such centers. Obviously the cooperation of practicing physicians and the centers will be essential to realize these potential benefits. And in the future, it should be remembered that physicians representing both organized medicine and medical schools must participate fully in the earliest stages of legislative planning and implementation.

● Dr. Coble, 2700 Riverside Avenue, Jacksonville 32205.

Dr. Coble is Chairman of the Florida Diabetes Advisiory Council.

Protein Power
Or
"Doctor, You Don't Mind If I Try A New Diet A Little While, Do You?"

Yank D. Coble Jr., M.D.

In this age of inherent conflicts between our thin standards of beauty and our fat standards of living, few physicians are unaware of the plethora of gimmick diets for weight reduction and control. In the past, little apparent harm has been documented from such diets, although the frequent and carefully worded escapes from responsibility or liability in these diet books (i.e., "be sure to consult with your physician before starting this diet") implied the authors have had no small concern of risks to the patient and/or themselves.

But now, the "liquid protein diets" have readily demonstrated that the legal concerns of the "fat doctors" have been merited. The most recent "in" diet — liquid protein supplements promoted as "modified fasting" diets and touted as being "protein sparing" — has been implicated convincingly in the deaths of nearly 50 young adult females, most of whom were without known disease. Several of these women, including at least one in Florida, were under medical supervision. The cause of their demise was unclear although hypokalemia and arrhythmias were implicated in a number.

The Food and Drug Administration (FDA) has requested that physicians report any ill effects associated with the protein supplement diets. The more serious clinical problems observed have included cardiac arrhythmias, gout, dehydration and hypokalemia. Common complaints reported include nausea, vomiting, diarrhea, constipation, faintness, muscle cramps, weakness or fatigue, irritability, cold intolerance, decreased libido, amenorrhea, hair loss and skin dryness. Reports can be mailed to the FDA or telephoned directly to Richard Swanson, (301) 443-4667.

At the American Society of Parenteral and Enteral Nutrition in Houston in February 1978, researchers and clinicians working in the area of modified fasting and protein sparing regimens strongly expressed their opinion that (1) high protein diets were no more effective than other dieting regimens in promoting weight loss, (2) consumption of protein alone would not maximize the burning of body fat while conserving muscle tissues and other protein sources, and (3) there was no evidence of long term success with weight loss under this regimen. The experimental nature at present of the modified fasting and protein sparing diet was reaffirmed. In addition to the nutritional concerns, the Food and Drug Administration has expressed reservations regarding the quality of the protein present, the wide variability of composition of the protein, and the presence of bacteria and other contaminates.

Thus, if your patient calls with the apparently innocuous little question about starting his new or "last chance diet," the thought and concern is certainly warranted that this may well be his "last diet."

Dr. Coble is Chairman of the FMA Council on Scientific Activities.

● Dr. Coble, 2700 Riverside Avenue, Jacksonville 32205.

To feel that you have done what should be done raises you in your own eyes. — Eugene Delacroix

EDITORIALS

Controlling the Cost of Medical Care

The ever-increasing cost of medical care demands that we, as physicians, do our fair share to contain, if not reduce, that cost. In excess of $120 billion was spent on personal health care in 1976. Directly and indirectly approximately $93 billion, or 77% of this, was generated by practicing physicians. It is only we, the physicians, who can admit patients to hospitals and order procedures and prescribe drugs and treatment. We are unique among professions and industries in that our clients, our patients, depend upon us to tell them what medical care is appropriate and how much of it they should purchase at any given time. This places upon us, the members of the medical profession, the burden of caution and responsibility in the utilization of our patients' health care dollars.

FMA Priority 1977-78

". . . Careful analysis and implementation of a program dealing with the cost of medical care to include continued study and implementation of programs to assist in containing the rapid increase in the cost of medical care including evaluation and appropriate action of proposed cost containment legislation . . ."

It has become popular for all segments of the public to become involved in studying the cost of medical care, and proposing ways in which to control that cost. One does not even have to look to Washington for an example. We have had occasion to witness the enthusiasm with which certain members of the Florida State Legislature wish to control the practice of medicine in Florida. The Cost Containment Act of 1975, for instance, nurtured by a powerful Senator who was then Chairman of the Senate HRS Committee, would have created a commission in Tallahassee whose responsibility would have been to set rates prospectively for every private hospital and nursing home in the State of Florida. This would have effectively nullified the function of all the boards of directors, trustees and governors of those private institutions in our State. The wish to control doctors in their private office practice has been only thinly veiled, if at all.

Three years ago, the President of the FMA, Vernon B. Astler, M.D., created a Cost of Medical Care Committee which has been continued under the administrations of Jack A. Macris, M.D. and Louis C. Murray, M.D. This committee, including non-M.D. members of the Health Delivery System, has met on numerous occasions and has studied and produced reams of material. One of the first goals of the committee was to identify those areas in which the medical profession has some control over the increasing cost of medical care. It quickly became apparent that there are many areas where there was absolutely no control by doctors or hospital people. We have no control, for instance, over increase of costs of utilities, supplies, postage, insurance, phone service and the increasing expenses of building and maintenance.

We have no control over the Minimum Wage Law, which, as of January 1, 1978, has increased once again, this time from $2.30 to $2.65. The hospital personnel came under the Minimum Wage Law as of several years ago and this has, in no small way, increased the cost of hospital care. Hospitals have from 50% to 70% of their entire budgets

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Editor's Note: The above editorial is another in a series **The Journal** is publishing on FMA's priorities for 1977-78.

devoted to labor costs. Jack Monahan, Executive Director of the Florida Hospital Association, estimates that in 1978 the most recent minimum wage boost will increase the hospital costs in Florida 9%, or some $20 million. These increases, of course, will be borne ultimately by purchasers of health insurance and by users of the facilities and services.

Twenty-five years ago there were less than 100 laboratory tests available to doctors. Today, there are over 600! Studies have shown that practicing physicians generally are unaware of the cost of diagnostic tests and procedures they order. The FMA Cost of Medical Care Committee has urged all the hospitals in the State of Florida to post their charges for commonly ordered laboratory procedures so as to help educate the practicing physicians in those institutions. This committee has also recommended the elimination of "routine admission orders." It is costly and superfluous, for example, to order a chest x-ray on a patient whose chest has just been x-rayed in the doctor's office the week before admission to the hospital. There is no indication that the routine ordering of VDRL, prothrombin time, SMA-12, chest films, EKG and similar tests warrants the tremendous cost involved. There is some fear that too much reliance has been placed upon laboratory study diagnoses, rather than careful history taking and physical examination.

The recommendations of the FMA Cost of Care Committee boiled down to more careful and judicious ordering on the Order Sheet, for that is exactly where we, as physicians, have input and some influence upon the cost of our patients' medical care. We should not overutilize private rooms; we should eliminate "routine orders"; we should question the necessity of admitting the day before some surgeries; we should eliminate unnecessary laboratory testing and x-ray examinations; we should eliminate excessive utilization of physical therapy services, inhalation therapy services, special duty nurses.

We should question the high cost of Emergency Room care, including excessive charges for treatment, duplicate charges for reading x-rays, unnecessary laboratory and x-rays and duplicate charging for services rendered by Emergency Room physicians, as well as the consultant physician.

We should question the need for hospitalization for "general checkups." We should avoid hospitalization for minor or office type surgery and workups simply because of "insurance coverage." We should reduce "defensive medicine tactics."

The term "unnecessary surgery" has been used liberally in the press. We should define necessary surgery, elective surgery, emergency surgery, cosmetic surgery, reconstructive surgery, etc. Cosmetic surgery should not be disguised as "reconstructive surgery" simply for the purpose of having a third party insurance company pay for the procedure.

We should increase physicians' awareness and concern for hospital medical costs. We should avoid the use of highly skilled, expensive personnel, when non-skilled personnel will suffice. We should question the practice of charging the patients professional component for diagnostic x-ray interpretation after the treatment has been rendered. We should question the practice of pathologists' professional charges for work not actually supervised. We should question anesthesiologists charging for work done by anesthetists, except under the most rigid criteria. We should question the practice of EKG panels in which there is frequently duplicate charging for single service. When the admitting physician is, himself, an internist, perfectly capable of reading his own EKG's, the panel is superfluous. We should question the practice of physicians and surgeons charging for house staff services, when the physician, himself, is not present.

We recognize there is increased cost to patients admitted to medical school affiliated teaching programs and observe that the patient is subsidizing the teaching program by those increased charges, in addition to paying for the actual cost of his diagnostic investigation and care.

We endorse the elimination of unnecessary hospitalization simply because of insurance or liability consideration, i.e., that some third party will pay for it.

We recognize that ambulances are used when frequently the automobile is available and would suffice. We caution ourselves not to fall into the trap of continuing hospitalization "for one more day" for any other than good medical reasons. It is not sufficient, for instance, to wait and send Aunt Minnie home on Monday because the family finds it inconvenient to bring her home on Saturday or Sunday. We endorse the availability of less expensive nursing home facilities so as to free the higher cost acute general hospital beds. We question the wisdom of duplicating extremely expensive and sophisticated diagnostic and treating equipment in the same community. We also question the over expansion of hospital beds and

then encouraging efforts at filling those surplus beds.

This question of the Cost of Medical Care is certainly not a simple one and many answers, which superficially seem simple, serve to complicate the problem. For instance, to eliminate many cases as in-hospital admission and then treat them in a separate "one day surgical center" does not necessarily lower the overall health cost of the community. The overhead of the hospital is spread over all patients and to eliminate many cases as in-hospital admissions will, of course, increase the cost shared by those patients having more serious operative procedures and more serious conditions.

Twenty-five to 50% of the beds in the American hospitals are occupied by patients over 65 and these peoples' average stay in the hospital is 12.6 days, more than twice that of younger patients. The loaf of bread these senior citizens buy today is not a great deal different from the loaf they bought in their youth, but costs a great deal more. The automobile they buy in 1978 affords them only transportation, but costs a great deal more than it did in their youth. The hospital day in 1978 bears no resemblance to the hospital day that was afforded them in their youth. Virtually all ailments and treatments with which hospitals are concerned today have little to do with what took place 25 years ago. The hospital day does cost more and the product is a much more sophisticated and constantly improving product.

We physicians have been educated to make available to our patients the most up-to-date treatment. We have never been trained to weigh cost against benefit. The recent malpractice crisis has served only to exaggerate our feelings that we must diagnose and treat regardless of the cost.

However, if the medical profession does not take positive steps to control the rising cost of health care, we are going to find BIG BROTHER with his bureaucratic and paternalistic actions and attendant increased costs attempting to exert control, but only driving the costs higher. We should not approach any of the government proposals with the sole purpose of thwarting them, but instead we must prove that we are capable of doing it better and less expensively without government control. If we are not successful in voluntarily reducing costs in our own hospitals, we may find caps being placed on all facets of our profession and not just the hospital costs. It is the considered opinion of FMA Cost of Medical Care Committee that the most useful tool we have at hand is effective Peer Review at the local level. Effective Peer Review should be an educational process for all of us, pointing out to each of us ways in which was can reduce the cost to our patients. An effective Peer Reivew system in each and every institution in the State of Florida can identify those of us who have a tendency to hospitalize patients unnecessarily or for too long a period, order too many laboratory tests and, in general, overutilize the patients' medical care dollar.

A Peer Review system should be physician supported as a responsible action to serve not only the patient and the public, but also the profession. It has the capability of saving the people of Florida many millions of dollars a year and is a far more palatable alternative than absolute control by BIG BROTHER. Peer Review will be punitive to the unscrupulous, but educational to the unwary or unwise. In practice it should serve as a valuable tool for the physician who, at times, is forced to argue with patients and families against unnecessary or inappropriate use of health care facilities.

Time is running out for us to demonstrate greater responsibility in our stewardship of our patients' resources. — **James F. Richards, Jr., M.D., Orlando, Chairman, FMA Council on Medical Economics, and Chairman, Special Commlttee on the Cost of Medical Care.**

The end of wisdom is to dream high enough not to lose the dream in the seeking of it.

—William Faulkner

The Medical Mutes

Arlington has its Unknown Soldier and county and state medical associations their Medical Mutes. The former rests in marbled grandeur on the banks of the historic Potomac in the beautiful National Cemetery; the latter are scattered throughout the United States. The martyred warrior is shrouded in impenetrable anonymity in the great stone tomb that holds his revered remains, and the Medical Mutes are shut away in the dense silence and intellectual vacuum that encompasses them.

What are Medical Mutes? They are physicians of the silent majority — mere scenery figures in the limbo of obscurity. They pay their dues and assessments and are duly inscribed on the associations' rolls as members. Over the years they become alienated from their fellows and reconciled to their own progressive obsolescense. There are two subspecies: those who never talk about their association's affairs and those who say nothing even when they rise and rend the air. The latter outnumber the former; yet there is little difference between them in intellectual vacuity.

A much stronger systemic capacity must be developed among the Medical Mutes. Medical leaders should induce them to express their personal views and to act responsibly. They must be started on the path of enlightenment. Muteness—forbearance from speaking — in county, state and national association deliberations must end. Talking to each other is the superlative political act.

Medical Mutes must help quell the PSRO confrontations, remove inequalities in fee schedules, beautify the dehumanized medical landscape, vindicate the innocent and punish the wrongdoers in medicine. Physicians must not remain mute if they wish to deal effectively with the problems of change. And physicians must not continue in attitudes inherited from their ideological past.

In the medical milieu acceleration of the rate of change has transformed the understanding of our responsibilities. Resolution of this acceleration may well determine the success and survival of free medicine in America. Now we live long enough to witness the consequences of our actions. Until recently the physician lived as an ideologist sheltered from the harsh reality of conflicts that disturb other societies. His influence was evident only in matters of theory and principle, not when responsible decision-making was concerned. The speeding up of change that medicine currently is experiencing, or perhaps from which medicine is benefiting, makes it important that physicians start considering change as a practical problem. To most innovation is problematic; they are reluctant to tackle it because at first sight, like all integrative concepts, innovation is confusing and contradictory. To many creativity means nonconformity.

Many physicians have come to know the forces governing them and are exercising tighter control over themselves. Now a better understanding of reality and of their own potential is forcing many association leaders to act. Medical Mutes affiliated for action and possessing some measure of resiliency, drive, and endurance can stimulate the powers that be to make further changes.

The Medical Mutes throughout America are an unlimited human potential to contain the peculiarly restrictive powers of the medical bureaucrats. The silent majority in medicine are needed in the struggle to guarantee that the rights abide with the patients and their physicians rather than in the preserves of medical bureaucratic power.

Muteness must end and with new wellsprings of human spirit it will be possible for the American Medical Association to be organized of, by and without question for physicians.

Edward Pedrero Jr., M.D.
Tampa

The less one has to do, the less time one finds to do it in. — Lord Chesterfield

Florida Cost of Medical Care Committee Has Organizational Meeting

The Florida Committee on the Cost of Medical Care, sponsored by the Florida Medical Association conducted its organizational meeting at the FMA Headquarters in Jacksonville on March 11.

The Committee is co-sponsored by the Florida Hospital Association, Blue Cross-Blue Shield, and the Florida health insurance industry. At the March meeting, the Committee decided to extend an invitation to representatives of organized labor and industry to participate.

An effective, multifaceted program to contain and explain health care costs was identified as a top priority. The Committee intends to coordinate a program to monitor and evaluate the impact and effectiveness of voluntary cost containment measures in the State.

Immediate plans call for each member organization to prepare an inventory of specific programs and their effectiveness to date, specific goals and plans to implement them in the future.

Mr. Salvo A. Mudano, Administrator of Memorial Hospital, Hollywood, was elected Chairman of the Committee, succeeding FMA Vice President J. Lee Dockery, M.D., of Gainesville, who served as temporary Chairman.

Other officers of the Committee are: Miss Betty Gurney, Prudential Insurance Company, Jacksonville, representing the Health Insurance Council, Vice Chairman; and J. Champneys Taylor, M.D., of Jacksonville, Secretary.

The Committee planned to meet again on April 6 in Tallahassee.

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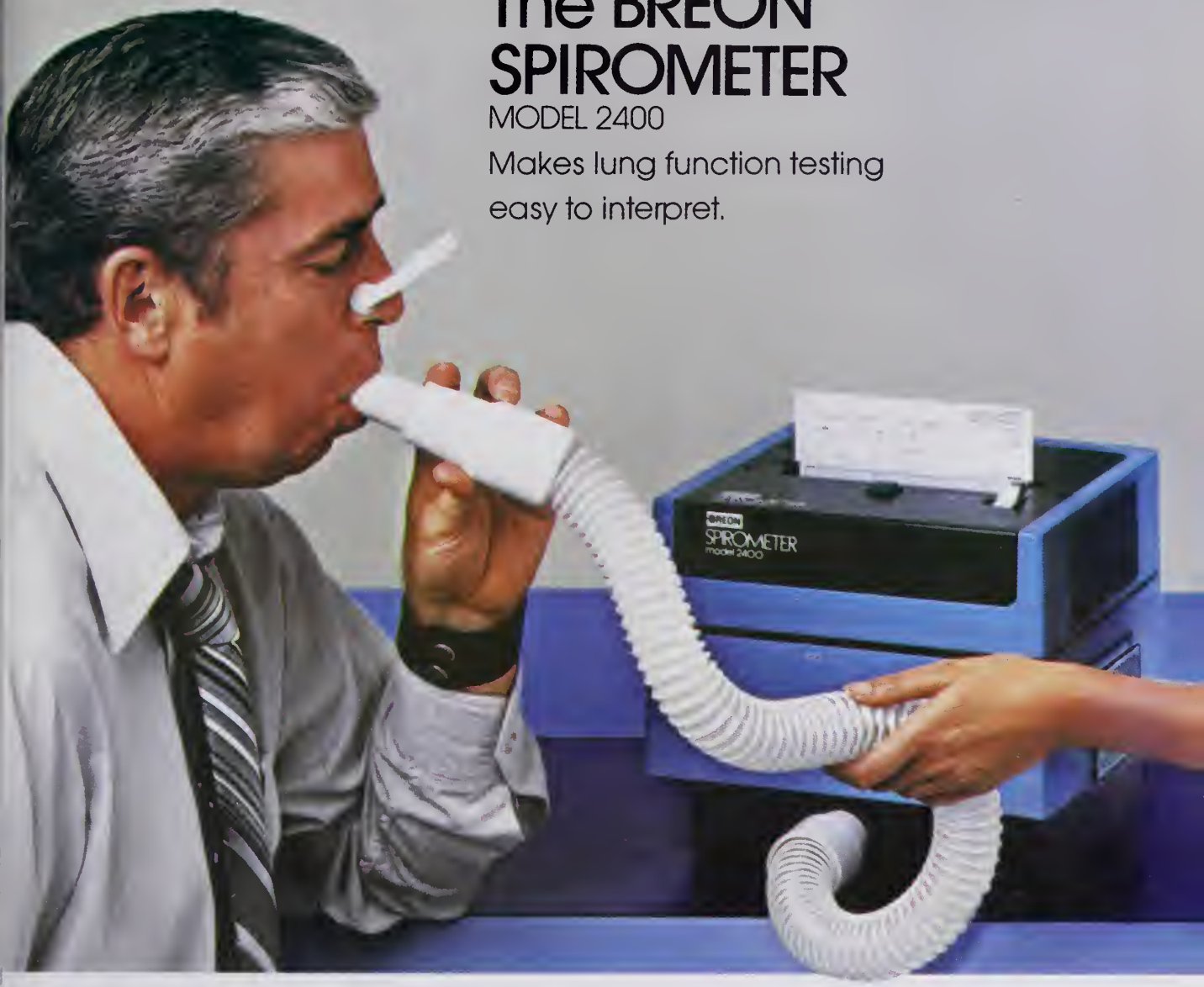
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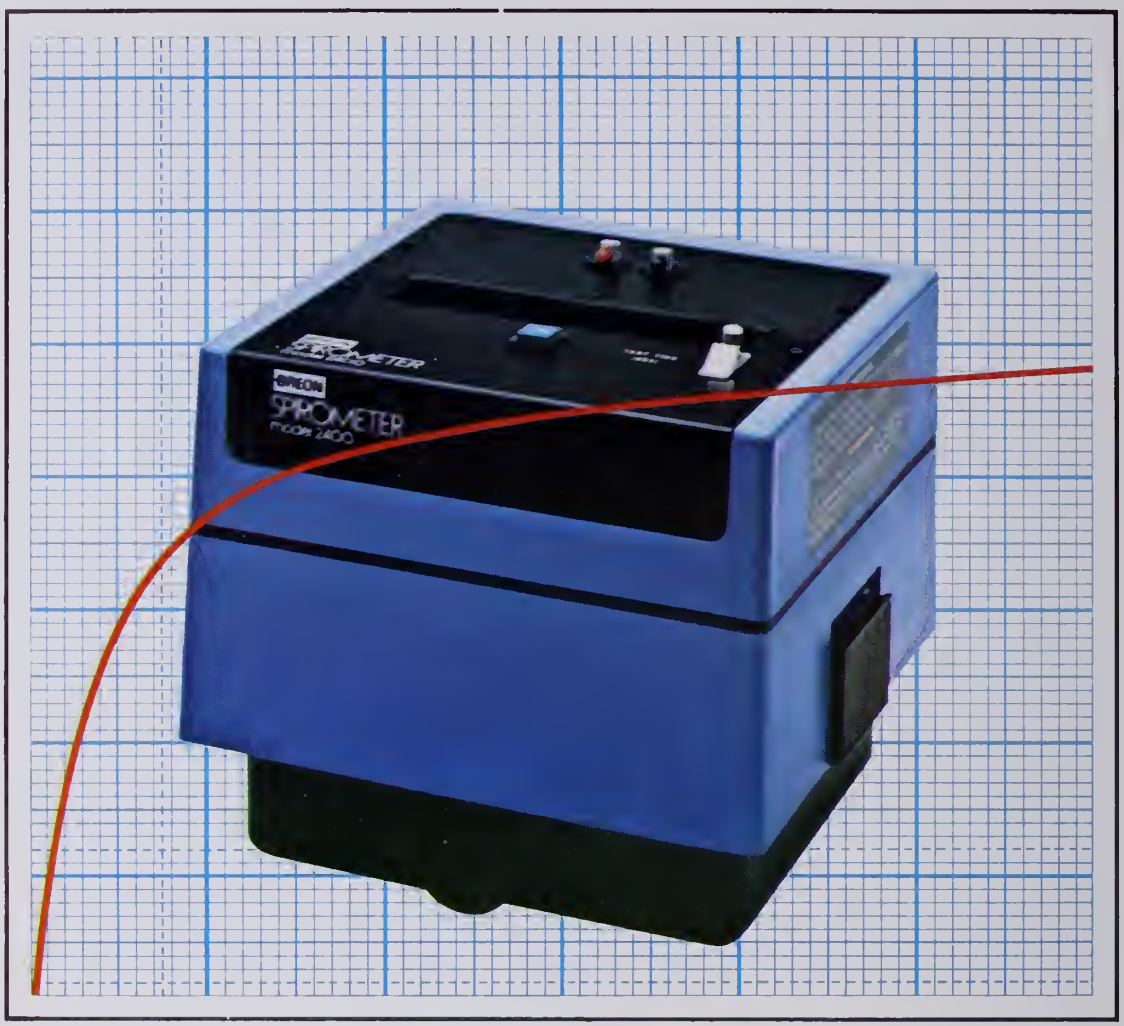
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Summary of the FMA Board of Governors Meeting March 11, 1978

The following is a summary of the actions taken by the Board of Governors at its meeting on March 11, 1978.

THE BOARD:

1979 ANNUAL MEETING

Directed that the 1979 FMA Annual Meeting currently scheduled to be held in Lake Buena Vista, Florida, May 2-6, be rescheduled at the Diplomat Hotel and that all future Annual Meetings be held at the Diplomat Hotel until such time as suitable alternate locations are determined.

FMA LEADERSHIP CONFERENCE

Approved tentative meeting dates for the FMA Leadership Conference through 1983 and directed that this meeting be held in the DisneyWorld area.

PL 93-641 NATIONAL HEALTH PLANNING AND DEVELOPMENT ACT

Expressed support for amendments to PL 93-641 that reflect the following:

1. Any National guidelines for health planning be strictly advisory.

2. The basic principle of health planning should be determined at the local level and not mandated by federal or state government.

3. The classification of "indirect provider" should be eliminated thus allowing more position on the state health coordinating council and HSA governing bodies for actual health care providers.

4. Instead of decertifying duplicative or unneeded health services or facilities, such services or facilities should be converted to meet other health needs.

5. "Certificate of need" should not be a part of the National Health Planning and Resources Development Act of 1974.

6. Doctor's offices should not be subject to "Certificate of Need."

7. VA facilities and HMO's should be covered under the act instead of receiving special privileges.

8. The Governor of a state should have the final sign off on the State Health Plan.

9. The State Health Plan should be consistent with state law.

10. The authority of the Secretary of HEW to establish a uniform system for rate calculation, and a system for classification of health services institutions should be eliminated.

11. Training programs for State Health Coordinating Council members and HSA governing body members should represent the thinking of providers as well as planners.

12. The activities of the State Health Planning and Development Agency (SHPDA) should be coordinated through the State Health Coordinating Council (SHCC).

13. The final decision on certificate of need should rest with the SHCC as opposed to HEW.

14. That in order to insure the quality of medical care to be continued in the United States that PL 93-641 be repealed.

MEDICAID

Authorized the Florida Medical Foundation to continue in pursuing the concept of development of a demonstration project on health care for the indigent through the pre-payment mechanism (openwall HMO).

HOSPITAL STAFF PRIVILEGES

Reaffirmed the current policy of the Association adopted by the FMA House of Delegates in May, 1977 regarding hospital staff privileges.

DRUG INSERTS

Expressed opposition to legislation which would require that drug inserts contain information other than drug efficacy.

CONTINUING MEDICAL EDUCATION

Directed that physicians heretofore exempted from the FMA individual CME program be required to begin their first three-year cycles no later than January 1, 1979 (Cycle 3); and that physicians in parttime practice whose required numbers of CME hours have been reduced to levels commensurate with the number of hours they spend in practice per week be made subject to the full requirements of the CME Program for the three year cycle beginning Jan. 1, 1979.

LAETRILE

Determined that Laetrile is clearly harmful in that it encourages abandonment of scientific treatment for cancer. Victims of the various malignant diseases are tragically drawn to this scientifically unproven remedy because of the ease of its administration. This results in the unnecessary loss of life and adds to human suffering.

MOXIBUSTION

Took the position that the practice of moxibustion (application of heat to acupuncture points by burning moxa—dried leaves) is a cult.

HOME DELIVERY IN OBSTETRICAL CARE

Supported the position of the Florida Obstetrical and Gynecologic Society regarding home delivery in obstetrical care, "in the interest of the health and safety of the mother and child that delivery at home be opposed and encourage all obstetricians and hospitals delivering obstetrical care to explore alternative modes of delivery within the hospital setting which offers maximum safety for mother and baby as economically as possible."

9-1-1 EMERGENCY PHONE SYSTEM

Directed that each county medical society be notified that there is state funding available for implementing the 9-1-1 Emergency Phone System on a statewide basis and requested that the county medical society encourage its local municipalities to implement this system which has lifesaving potential.

AMPHETAMINES

Endorsed the action taken by the Duval County Medical Society, Jacksonville Area Osteopathic Society and Jacksonville Pharmaceutical Association to voluntarily remove all amphetamines and methaqualone from the shelves of local pharmacies, and requested all component county medical societies to explore the feasibility of a similar program in their own local areas.

STATE LEGISLATIVE COMMUNICATION

Directed that county medical societies be advised as to the various types of state legislative information that is available upon request including the Senate and House calendars, and how this information may be obtained on a regular basis.

COUNTY MEDICAL SOCIETY GRIEVANCE PROCEDURES

Requested the FMA Judicial Council to distribute to the county medical societies a general outline of due process procedures to be followed by county medical societies in resolution of a grievance against one of its members and urged county medical societies to review their by-laws to be sure they follow due process.

MEDICAL PRACTICE ACT

Adopted a position of strong support for additional funding for the Board of Medical Examiners, that would allow the Board to carry out its responsibilities including the hiring of additional attorneys to prosecute cases of violation of the Medical Practice Act.

ADVERTISING

Requested that the Judicial Council adopt guidelines for advertising routine fees by members of the Florida Medical Association.

LEGISLATION

Adopted the following positions regarding legislation to be introduced in the 1978 session of the Florida Legislature.

- Opposed legislation which authorizes physical therapists to use acupuncture and which allows treatment by a physical therapist upon "referral" of a physician (SB 155).

- Opposed legislation removing the exemption for groups of five or less physicians from application of the Clinical Laboratory Act.

- Opposed provisions to tax out-of-state physicians as a method to provide medical services to medically under served areas.

- Opposed legislation to mandate that optometrists be appointed to all health advisory committees.

- Opposed legislation that encourages abandonment of the County Health Department approach in favor of District Health Departments in Florida and urged increased funding for County Health Departments.

- Disapproves legislation that legalizes the use of DMSO in Florida (HB 734).

- Expressed vigorous opposition to any legislation that would require complaint files and reports made to professional licensing boards be open to the public.

ORGANIZATION

Dr. MaCris Receives Award from the International Physicians Education Network, Inc.



Jack A. MaCris, M.D., of St. Petersburg (center), displays a "Visile Medical Society Leader" Award he received from the International Physicians Education Network, Inc. (PEN). Dr. MaCris, Immediate Past President of the Florida Medical Association, was cited "for his personal efforts and leadership in resisting the invasion of medicine by non-medical practitioners." Also pictured are Alton Ochsner, M.D., of New Orleans (left); and Kenneth R. Safko, M.D., of St. Petersburg, a PEN Director.

Death Claims Dr. Rowland Wood, Former FMA Vice President

Rowland E. Wood, M.D., who served as Third Vice President of the Florida Medical Association in 1955, died in St. Petersburg on January 31. He was 62.

A native of St. Petersburg, Dr. Wood had practiced internal medicine in that city for 32 years. He was a graduate of the University of Florida and received his M.D. degree from Jefferson Medical College of Philadelphia.

During World War II, Dr. Wood served as a Medical Corps officer in General Patton's Third Army in Europe. He returned to St. Petersburg to practice after the war and later served a term as President of the Pinellas County Medical Society.

Among the survivors are the widow, one son and one daughter.

34 Scientific Sections Arranged For FMA Annual Meeting

Thirty-four scientific section programs have been arranged for the 104th Annual Meeting of the Florida Medical Association next month.

The meeting — at the Diplomat Hotel in Hollywood, May 3-7 — will be co-sponsored by the Medical Education Committee of the Florida Medical Foundation, which has certified the program as meeting the criteria for 20 hours of American Medical Association Category I Credit.

According to Henry M. Yonge, M.D., of Pensacola, Scientific Program Chairman, 33 of the 37 state specialty groups recognized by the FMA are participating. Scientific sessions will be conducted on Wednesday afternoon, May 3; Thursday afternoon, May 4; Friday morning and afternoon, May 5; and Saturday morning and afternoon, May 6.

FMA members may earn up to 20 hours of Mandatory Credit under the FMA's continuing medical education program for members. In addition, the American Academy of Family Physicians has found certain elements of the program acceptable for Prescribed Credit as follows:

—Section on Family Practice (3½ hours)
—Section on Nuclear Medicine and Family Practice (2½ hours)
—"Dialogue" Programs (1 hour each, total of 4)
—Programmed Instruction on the AutoTutor (1 hour each)

Dr. Yonge said the meeting also would feature many interesting scientific and educational exhibits. A listing of these appears elsewhere in this issue of *The Journal.*

There is no registration fee for FMA and AMA members, FMA invited guests, guest speakers, interns and residents. There is a registration fee for all other physicians who are not FMA or AMA members.

Here is the day-by-day scientific program:

WEDNESDAY AFTERNOON — MAY 3

SECTION ON INTERNAL MEDICINE

(Co-sponsored by American College of Physicians and Florida Society of Internal Medicine)

Wednesday, May 3 — 1:00 p.m. to 4:15 p.m.

George J. Caranasos, M.D., Gainesville
Program Chairman

"**Gastrointestinal Absorption and Obesity,**" James J. Cerda, M.D., Professor of Medicine, University of Florida College of Medicine, Gainesville.

"**Surgical Approach to Obesity: Present Status,**" J. Patrick O'Leary, M.D., Associate Professor of Surgery, University of Florida College of Medicine, Gainesville.

"**Nutrition for the Now Generation,**" Howard Appledorf, Ph.D., Associate Professor of Human Nutrition, University of Florida, Gainesville.

THURSDAY AFTERNOON — MAY 4

SECTION ON RHEUMATOLOGY

(Co-sponsored by Florida Society of Rheumatology)

Thursday, May 4 — 1:30 p.m. to 4:30 p.m.

Bernard F. Germain, M.D., Tampa
Program Chairman

"**Infectious Arthritis,**" Frank Schmid, M.D., Professor of Medicine and Chief, Section of Arthritis/Connective Tissue Diseases, Northwestern University Medical School and Director, Arthritis Clinical Center, Northwestern University Medical Center, Chicago, Illinois.

"**Psoriatic Arthritis,**" Frank B. Vasey, M.D., Assistant Professor of Medicine, Section of Rheumatology, University of South Florida College of Medicine, Tampa.

"**Radiologic Manifestations of Rheumatic Diseases,**" Roy Altman, M.D., Associate Professor of Medicine, University of Miami School of Medicine, Miami.

Case Presentations and Discussions

SECTION ON BASIC LIFE SUPPORT CERTIFICATION

(Co-sponsored by Florida Chapter, American College of Emergency Physicians, in Cooperation with the Heart Association of Greater Miami)

Thursday, May 4 — 2:00 p.m. to 5:00 p.m.

Basic life support is an emergency first aid procedure that consists of the recognition of respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life until a victim recovers sufficiently to be transported or until advanced life support is available.

The 1976 FMA House of Delegates encouraged all Florida physicians to become certified in basic life support.

This course is open to spouses and other family of FMA members. A registrant who successfully completes the course will receive certification in basic life support from the American Heart Association.

This course is practical in nature and registrants should be prepared to participate actively. A demonstration of practical skills is a prerequisite for successful course completion and certification.

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Chapter, American College of Chest Physicians and Florida Thoracic Society)

Thursday, May 4 — 2:00 p.m. to 5:00 p.m.

A. Jay Block, M.D., Gainesville
Marcos Barrocas, M.D., Miami
Program Co-Chairmen

"Selected Topics in Noncardiogenic Pulmonary Edema"

Moderator: Roy Behnke, M.D., Chairman, Department of Medicine, University of South Florida College of Medicine, Tampa.

"Overview and Definition," Roy Behnke, M.D., Chairman, Department of Medicine, University of South Florida College of Medicine, Tampa.

"Near Drowning," Jerome Modell, M.D., Chairman, Department of Anesthesiology, University of Florida College of Medicine, Gainesville.

"Aspiration Pneumonia," James W. Wynne, M.D., Assistant Professor of Medicine and Anesthesiology, University of Florida College of Medicine, Gainesville.

"Traumatic Pulmonary Edema," Richard Virgilio, M.D., Chief, Shock Trauma Unit, Naval Regional Medical Center, San Diego, Calif.

FRIDAY MORNING — MAY 5

SECTION ON OTOLARYNGOLOGY

(Co-sponsored by Florida Society of Otolaryngology)

Friday, May 5 — 8:00 a.m. to 10:45 a.m.

W. Mark Flintoff, M.D., Pompano Beach
W. W. McClerkin, M.D., Pompano Beach
Program Co-Chairmen

Allergy Quiz and Questionnaire

The Fitting and Dispensing of Hearing Aids: Point-Counterpoint (Discussion)

Clinical Pathological Conference

Moderator:

Anthony J. Maniglia, M.D., Associate Professor of Otolaryngology, University of Miami School of Medicine, Miami.

Panelists:

Thomas C. Tyler, M.D., Venice
James F. Holly, M.D., Orlando
Robert K. Middlekauff, M.D., Jacksonville

"The Ear Surgeon of Tomorrow," J. Brown Farrior, M.D., Clinical Professor of Surgery, University of South Florida College of Medicine, Tampa.

SECTION ON NUCLEAR MEDICINE AND FAMILY PRACTICE

(Co-sponsored by Florida Association of Nuclear Physicians and and Florida Academy of Family Physicians)

Friday, May 5 — 8:00 a.m. to 10:45 a.m.

Aldo N. Serafini, M.D., Miami Beach
E. F. Ciliberto, M.D., Tampa
Program Co-Chairmen

Introduction — E. F. Ciliberto, M.D., Chief of Undergraduate Education Section, Department of Family Medicine, University of South Florida College of Medicine, Tampa.

"Toxicology Update — Role of Radioimmunoassay and Other In Vitro Techniques," Laudie E. McHenry, M.D., Department of Pathology, Brevard Hospital, Melbourne.

"Thyroid Nodular Disease — Benign or Malignant," Fuad S. Ashkar, M.D., Associate Professor of Radiology and Medicine and Director of the Radioassay Laboratory, Jackson Memorial Hospital and University of Miami School of Medicine, Miami.

"Hodgkin's and non-Hodgkin's Lymphomas — Diagnosis, Staging and Management," Michael B. Troner, M.D., Assistant Professor of Medical Oncology and Chief of the Medical Oncology Service, VA Hospital, Miami.

"Hepatobiliary Scanning in Acute Cholecystitis," Edward A. Eikman, M.D., Assistant Professor of Medicine, University of South Florida College of Medicine, and Chief of Nuclear Medicine, VA Hospital, Tampa.

"Myocardial Imaging in the Detection of Ischemic Heart Disease and Myocardial Infarction," Aldo N. Serafini, M.D., Assistant Professor of Radiology and Assistant Director of Ultrasound Section, Division of Nuclear Medicine, University of Miami School of Medicine, Mt. Sinai Medical Center, Miami Beach.

"The Role of Short Lived Radio Gasses in Cardio-Pulmonary Disorders," A. J. Gilson, M.D., Professor and Director of the Division of Nuclear Medicine and Ultrasoundography, University of Miami School of Medicine, Mt. Sinai Medical Center, Miami Beach.

"Complementary Role of Echocardiography and Nuclear Imaging in Cardiology," S. Gottlieb, M.D., Assistant Professor of Radiology and Medicine, Division of Nuclear Medicine, Department of Radiology, Jackson Memorial Hospital, Miami.

"Pediatric Nuclear Medicine," Dorothy T. G. Lloyd, M.D., President, Florida Association of Nuclear Physicians, and Director of Nuclear Medicine, Orange Memorial Hospital, Orlando Regional Medical Center, Orlando.

Closing Remarks — Dr. Lloyd

SECTION ON EMERGENCY MEDICINE

(Co-sponsored by Florida Chapter, American College of Emergency Physicians)

Friday, May 5 — 8:00 a.m. to 10:30 a.m.

William T. Haeck, M.D., Ft. Lauderdale
Program Chairman

"Initial Management of the Patient in Shock" (Speaker to be Announced)

"Responsibilities of the Medical Director in the Supervision of Paramedics," J. Clifford Findeiss, M.D., Miami

"Drug Therapy During CPR — Essential and Useful Drugs" (Speaker to be Announced)

SECTION ON ORTHOPEDIC SURGERY (SECTION I)

(Co-sponsored by Florida Orthopedic Society)

Friday, May 5 — 8:00 a.m. to 10:45 a.m.

Joseph C. Flynn, M.D., Orlando
Program Chairman

Welcome — Ronald J. Mann, M.D., President, Florida Orthopedic Society, Miami.

"Correlation of Clinical Impressions and Arthroscopic Findings of 500 Consecutive Knee Examinations," Carl L. Croft, M.D., Winter Park.

"**Arthroscopy — An Update on 600 Cases,**" John P. Barrett, Jr., M.D., Clearwater.

"**Patellar/Femoral Complications in Total Knee Arthroplasty,**" Jerry E. Enis, M.D., Miami.

"**Total Knee Joint Replacements Utilizing the Marmor Modular Components,**" William H. Keeler, III, M.D., St. Petersburg.

Noiles Total Knee Replacement," Leo M. Flynn, M.D., Pensacola.

"**Iatrogenic Systemic Lupus Erythematosus,**" Michael S. Zeide, M.D., West Palm Beach.

DIALOGUE

(Presented through the Courtesy of Pfizer Laboratories and the Roerig Divisions of Pfizer Pharmaceuticals)

Friday, May 5 — 8:30 a.m. to 10:45 a.m.

Each one-hour segment of Dialogue will begin with a five- or ten-minute overview of a topic of current interest by a guest speaker. The remainder of each hour will include audience questions.

"**Management of Diabetes,**" John Colwell, M.D., Ph.D., Professor of Medicine and Director, Endocrinology-Metabolism-Nutrition Division, Medical University of South Carolina, Charleston, S.C.

"**Use of Antibiotics in Chest Infections,**" Malcolm T. Foster, M.D., Professor of Internal Medicine, University Hospital of Jacksonville, Jacksonville.

SECTION ON ENDOCRINOLOGY

(Co-sponsored by Florida Endocrine Society)

Friday, May 5 — 8:30 a.m. to 10:00 a.m.

Robert B. Katims, M.D., Miami
Peter N. Weissman, M.D., Miami
Program Co-Chairmen

"**Problems of Growth and Development in Children and Adolescents,**" Raphael Bejar, M.D., Clinical Associate Professor of Pediatrics, University of Miami School of Medicine, Miami.

"**Pituitary Tumors — New Techniques in Diagnosis and Management,**" Paul Jellinger, M.D., Clinical Assistant Professor of Medicine, University of Miami School of Medicine, Miami.

"**Pseudo-Endocrine Disease and Non-Disease,**" Yank D. Coble, Jr., M.D., Clinical Associate Professor of Medicine, University of Florida College of Medicine (JHEP), Jacksonville.

SECTION ON PEDIATRICS
(Co-sponsored by Florida Chapter, American Academy of Pediatrics, and Florida Pediatric Society)

Friday, May 5 — 9:00 a.m. to 10:30 a.m.

James A. Hallock, M.D., Tampa
Program Chairman

"**All You Wanted to Know About Perinatology But Were Afraid To Ask,**" Richard Boothby, M.D., Director, Florida Perinatal Association, Jacksonville.

FRIDAY AFTERNOON — MAY 5

SECTION ON NEUROLOGY

(Co-sponsored by Florida Society of Neurology)

Friday, May 5 — 1:00 p.m. to 5:00 p.m.

Alan Herskowitz, M.D., North Miami Beach
Program Chairman

"**Current Advances in Treatment of Autoimmune Diseases in Neurology,**" Robert Schwartzman, M.D., Associate Professor of Neurology, University of Miami School of Medicine, Miami.

"**Neuro-Oncology,**" Marvin Diaz-Lucayo, M.D., Attending Physician, Hematology-Oncology, Parkway General Hospital, North Miami Beach.

"**Current Concepts in the Treatment of Pain,**" Donald Dooley, M.D., Neurosurgeon and Medical Director, Pain Rehabilitation Center, Baptist Memorial Hospital, Miami; and Albert Ray, M.D., and Bernard Swerdlow, M.D., Psychiatrists and Attending Physicians, Baptist Hospital, Miami.

SECTION ON FAMILY PRACTICE

(Co-sponsored by Florida Academy of Family Physicians)

Friday, May 5 — 1:30 p.m. to 5:30 p.m.

E. Frank Ciliberto, M.D., Tampa
Program Chairman

Welcome — Dick L. VanEldik, M.D., President, Florida Academy of Family Physicians, Lake Worth.

"**The Gerontocracy: Sociodemographic Aspects of the Aging Population,**" E. Frank Ciliberto, M.D., Assistant Professor of Family Medicine, University of South Florida College of Medicine, Tampa.

"**Biologic Aspects of Aging,**" Alfred Laughton, M.D., Ph.D., Ridge Manor, Florida.

"**Psychologic Aspects of Aging,**" Jack Skigen, M.D., Clinical Assistant Professor of Psychiatry, University of Miami School of Medicine, Miami.

Questions and Answers/Panel

Moderator:

Henry L. Harrell, Sr., M.D., Ocala

Panelists:

E. Frank Ciliberto, M.D.
Jack Skigen, M.D.
Alfred Laughton, M.D., Ph.D.

Selected Topics — Presentations by Residents from the University of South Florida College of Medicine, Department of Family Medicine Affiliated Residency Programs

Responder Panel to Resident Presentations

SECTION ON THORACIC AND CARDIOVASCULAR SURGERY

(Co-sponsored by Florida Society of Thoracic Surgeons)

Friday, May 5 — 1:30 p.m. to 4:00 p.m.

Robert B. Trumbo, M.D., Orlando
Program Chairman

"**Indications for Coronary Artery Surgery,**" Harold C. Urschel, M.D., President-Elect, Southern Thoracic Surgical Association, and Clinical Professor of Surgery, University of Texas Southwestern Medical School, Dallas, Texas.

"Treatment of Hiatal Hernia and Reflux Esophagitis," Dr. Urschel.

Panel on Esophageal Disease

SECTION ON PSYCHIATRY

(Co-sponsored by Florida Council of District Branches of the American Psychiatric Association)

Friday, May 5 — 1:30 p.m. to 5:30 p.m.

Lionel H. Blackman, M.D., West Palm Beach
Program Chairman

"Understanding Psychosomatic Symptoms," Stanley Conrad, M.D., West Palm Beach.

"Psychosomatic Aspects of Alcoholism," Jose Almeida, M.D., Medical Director, Palm Beach Institute, West Palm Beach.

"Psychosomatic Medicine — Unity of Body and Mind," Irving J. Crain, M.D., Clinical Assistant Professor of Psychiatry, New York Medical College, New York, N.Y.

"Psychosomatic Disorders in the Hospitalized Geriatric Patient," Norman Silversmith, M.D., West Palm Beach.

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society for Preventive Medicine)

Friday, May 5 — 1:30 to 5:00 p.m.

James T. Howell, M.D., Palm Springs
Program Chairman

"Review of the Status of Maternal and Infant Care, State of Florida," Emily Gates, M.D., Family Health Program Medical Supervisor, Department of Health and Rehabilitative Services, and Staff, Tallahassee.

"The Cooperative Approach to Rural Maternity Care: University and County Health Departments," Charles S. Mahan, M.D., Project Director, NCF MIC-FP-WIC Projects, Gainesville.

"The Role of Nurse-Midwifery in Modern Maternal and Infant Care," Anne Scupholme, C.N.M., Department of Obstetrics and Gynecology, University of Miami School of Medicine, Miami.

Reactor Panel

June M. Murray, M.D., Director, Lake County Health Department, Tavares.

Samuel D. Rowley, M.D., M.P.H., Director, Duval County Health Department, Jacksonville.

Jorge Deju, M.D., M.P.H., Medical Administrator, Personal Health Program, Health Program Office, Department of Health and Rehabilitative Services, Tallahassee.

"Infectious Disease Update, State of Florida — To Include Dengue and St. Louis Encephalitis," R. Michael Yeller, M.D., Administrator, Disease Control, Department of Health and Rehabilitative Services, Tallahassee.

SECTION ON ORTHOPEDIC SURGERY

(Co-sponsored by Florida Orthopedic Society)

Friday, May 5 — 1:30 p.m. to 5:30 p.m.

Joseph C. Flynn, M.D., Orlando
Program Chairman

"Flexible Implant Arthroplasty of the Wrist — Technique and Results," Alfred B. Swanson, M.D., Grand Rapids, Mich.

"Spinal Stenosis," Mark D. Brown, M.D., Miami.

"Recent Developments in the Diagnosis and Treatment of Low Back Problems," Charles A. Mead, Jr., M.D., Jacksonville.

"Salvage Procedure for Failed Lumbar Disc Surgery," Richard G. Dedo, M.D., Jacksonville.

"Use of Harrington Instrumentation in Unstable Axial Skeletal Fractures," Max F. Riddick, M.D., Winter Park.

"Treatment of Advanced Spondylolisthesis," Harry L. Shufflebarger, M.D., Coral Gables.

"The TLSO for Kyphosis," Barry J. Silverman, M.D., North Miami Beach.

"Use of Silastic Membrane in Recurrent Turret Exostoses: A Case Report," Roger L. Bourguignon, M.D., Orlando.

SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Society of Colon and Rectal Surgeons)

Friday, May 5 — 1:30 p.m. to 4:30 p.m.

Walter W. Hamilton, M.D., St. Petersburg
Program Chairman

"Polyposis Syndromes in Relationship to Colon Cancer," J. Byron Gathright, Jr., M.D., Associate Clinical Professor of Surgery, Tulane College of Medicine, and Attending Staff, Department of Colon and Rectal Surgery, Ochsner Clinic, New Orleans, La.

"New Techniques in Diagnostic Radiology," Fred P. Gargano, M.D., Radiologist, Palmetto General Hospital, Hialeah.

"Local Transanal Excision of Adenocarcinoma of the Rectum," Jeff Harris, M.D., Colon and Rectal Surgeon, Tampa.

"Postoperative Ano-Rectal Bleeding," Emmet Ferguson, M.D., Colon and Rectal Surgeon, Jacksonville.

"Advances in Colonoscopy," John P. Christie, M.D., General Surgeon, Miami.

"Polyps of the Colo-Rectum: Current Status" (Panel)

Moderator: Walter W. Hamilton, M.D., Chief of Surgery, Palms of Pasadena Hospital, St. Petersburg.

Panelists: J. Byron Gathright, Jr., M.D., New Orleans, La.
Emmet Ferguson, M.D., Jacksonville
John Christie, M.D., Miami
Edward Willey, M.D., Pathologist, Palms of Pasadena Hospital, St. Petersburg.

DIALOGUE

(Presented through the Courtesy of Pfizer Laboratories and Roerig Divisions of Pfizer Pharmaceuticals)

Friday, May 5 — 2:00 p.m. to 4:15 p.m.

Each one-hour segment of Dialogue will begin with a five- or ten-minute overview of a topic of current interest by a guest speaker. The remainder of each hour will include audience questions.

"Management of Allergic Problems," Philip S. Norman, M.D., Professor of Medicine and Head, Clinical Immunology Division, Johns Hopkins University School of Medicine, Baltimore, Md.

"Approaches to Evaluation and Management of Primary Hypertension," James Gunnells, M.D., Professor of Medicine, Division of Nephrology, Duke University School of Medicine, Durham, N.C.

SECTION ON RADIOTHERAPY

(Co-sponsored by Florida Radiological Society)

Friday, May 5 — 2:00 p.m. to 4:30 p.m.

Leonard Shukovsky, M.D., Tampa
Program Chairman

"Radiotherapy and Surgery of the Head and Neck," Robert Lindberg, M.D., Professor of Radiotherapy, University of Texas Medical School and M.D. Anderson Hospital, Houston, Tex.

"Malignant Tumors of the Nasal Cavity-Sphenoid Sinuses with Special Attention to Eye Complications," Kenneth Ellingwood, M.D., Assistant Professor of Radiotherapy, University of Florida College of Medicine, Gainesville.

"Radiotherapy for Carcinoma of the Vagina," Russell Marcus, M.D., Department of Radiology, University of Florida College of Medicine, Gainesville.

"Soft Tissue Sarcomas: Combined Treatment," Robert Lindberg, M.D., Professor of Radiotherapy, University of Texas and M.D. Anderson Hospital, Houston, Tex.

SECTION ON RADIOLOGY
(SECTION I)

(Co-sponsored by Florida Radiological Society)

Friday, May 5 — 2:00 p.m. to 4:30 p.m.

Robert E. Williams, M.D., Lakeland
Program Chairman

Opening Remarks — Alfred Schick, M.D., President, Florida Radiological Society, and Chief Radiologist, Morton Plant Hospital, Clearwater.

"Skeletal Injuries in Sports," Lee F. Rogers, M.D., Professor and Chairman, Department of Radiology, Northwestern University Medical School, Chicago, Ill.

"C.A.T. vs. T.A.T. in the Spine," Fredie P. Gargano, M.D., Clinical Professor of Radiology, University of Miami School of Medicine, and Chief Attending Radiologist, Palmetto General Hospital, Miami.

"Gallium Imaging in Pediatrics," Richard E. Litt, M.D., Clinical Associate Professor of Radiology and Pediatrics, University of Miami School of Medicine, and Attending Radiologist, Variety Children's Hospital, Miami.

SECTION ON ENDOCRINOLOGY AND NEPHROLOGY

(Co-sponsored by Florida Endocrine Society and Florida Society of Nephrology)

Friday, May 5 — 2:00 p.m. to 4:30 p.m.

Robert B. Katims, M.D., Miami
John Cunio, M.D., Miami
Program Co-Chairmen

"Treatment of Renal Bone Disease with Newer Vitamin D Analogues," Jack W. Coburn, M.D., Professor of Medicine, UCLA School of Medicine, Los Angeles.

"Hyperparathyroidism — Problems in Diagnosis and Management," Eric Reiss, M.D., Professor of Medicine and Vice Chairman, Department of Medicine, University of Miami School of Medicine, Miami.

"Non-surgical Management of Hyperparathyroidism," Peter Weissman, M.D., Clinical Assistant Professor of Medicine, University of Miami School of Medicine, Miami.

SECTION ON DERMATOLOGY
(SECTION I)

(Co-sponsored by Florida Society of Dermatology)

Friday, May 5 — 4:00 p.m. to 6:00 p.m.

Gerald Weinstein, M.D., Miami
Program Chairman

Roundtable Clinical Discussion — (Open Question and Answer Format with Guest Speakers and Selected Local Dermatologists)

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathologists)

Friday, May 5 — 4:00 p.m. to 5:00 p.m.

Morton J. Robinson, M.D., Miami Beach
Program Chairman

"A Cross Match, Is It Necessary?" Herbert F. Polesky, M.D., Director, Minneapolis War Memorial Blood Bank and Professor of Laboratory Medicine and Pathology, University of Minnesota School of Medicine, Minneapolis.

SECTION ON UROLOGY AND OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society and Florida Urologic Society

Friday, May 5 — Time to be Announced

William A. Little, M.D., Miami
Victor A. Politano, M.D., Miami
Program Co-Chairmen

"Urological Complications Due to Gynecological Surgeries" (Speakers to be Announced)

SATURDAY MORNING — MAY 6

SECTION ON ALLERGY AND IMMUNOLOGY

(Co-sponsored by Florida Allergy Society)

Saturday, May 6 — 8:00 a.m. to 12:00 noon

Samuel C. Bukantz, M.D., Tampa
Program Chairman

"New Concepts in Etiology and Treatment of Asthma," Richard F. Lockey, M.D., Associate Professor of Medicine, University of South Florida College of Medicine, Tampa.

"Clinical Evaluation of Immune Disorders," Morton L. Hammond, M.D., Clinical Professor of Medicine, University of Miami School of Medicine, Miami.

"Occupational Asthma," John E. Salvaggio, M.D., Henderson Professor of Medicine and Director of Clinical Immunology Section, Tulane Medical Center, New Orleans, La.

"Clinical Uses of Transfer Factor," Hugh H. Fudenberg, M.D., Professor of Medicine, and Chairman, Department of Basic and Clinical Immunology, Medical University of South Carolina, Charleston, S.C.

SECTION ON RADIOLOGY (SECTION II)

(Co-sponsored by Florida Radiological Society)

Saturday, May 6 — 8:00 a.m. to 11:00 a.m.

Robert E. Williams, M.D., Lakeland
Program Chairman

"Angiographic Evaluation of Upper G.I. Disease," Martin Silbiger, M.D., Associate Professor of Radiology, University of South Florida College of Medicine, and Co-Director, Department of Biology, Tampa General Hospital, Tampa.

"Some Legal Problems in the Practice of Radiology," David Kirsch, M.D., Clinical Professor of Radiology, University of Miami School of Medicine, Miami.

"Trauma Quiz," Lee F. Rogers, M.D., Professor and Chairman, Department of Radiology, Northwestern University Medical School, Chicago, Ill.

SECTION ON ORTHOPEDIC SURGERY (SECTION III)

(Co-sponsored by Florida Orthopedic Society)

Saturday, May 6 — 8:00 a.m. to 11:35 a.m.

Joseph C. Flynn, M.D., Orlando
Program Chairman

"New Principles in Managing Lower Limb Rotational Deformities in Children," Allen S. Watson, Jr., M.D., Fort Lauderdale.

"Case Report of Ewing's Sarcoma of Fibula — A 2½ Year Survival," Wallace E. Miller, M.D., Miami.

"Orthopedic Education: Demands and Trends," Merlin G. Anderson, M.D., Tampa.

"Transacromial Approach to Rotator Cuff Tears of the Shoulder," Lester A. Russin, M.D., Miami Beach.

"Fourth and Fifth Metacarpal Dislocations with Associated Hamate Fractures," W. Lee Moffatt, M.D., and William E. Burkhalter, M.D., Miami.

"Flexible Implant Arthroplasty in the Toes and Elbow: Technique and Results," Alfred B. Swanson, M.D., Grand Rapids, Mich.

"A Quantitative, Comparative Analysis of Fracture Healing Under the Influence of Compression Plating Versus Closed Weight Bearing Treatment," Donald Mullis, M.D., Augusto Sarmiento, M.D., and Loren Latta, P.E., Miami.

SECTION ON NEONATAL-PERINATOLOGY AND PEDIATRIC CARDIOLOGY

(Co-sponsored by Florida Society of Neonatal-Perinatologists and Florida Association of Pediatric Cardiologists)

Saturday, May 6 — 8:30 a.m. to 10:45 a.m.

Richard L. Bucciarelli, M.D., Gainesville
David G. Ruschhaupt, M.D., Jacksonville
Program Co-Chairmen

"Management of the Infant with Patent Ductus Arteriosus," Lt. Col. Robert DeLemos, M.D., Department of Pediatrics, United States Air Force Medical Center, Lackland Air Force Base, Texas.

"Age Dependent Response of the Patent Ductus Arteriosus to Indomethacin," Jean McCarthy, M.D., Neonatologist, All Children's Hospital, St. Petersburg.

"Respiratory Management of the Infant with Congenital Heart Disease," Eduardo Bancalari, M.D., Assistant Professor of Pediatrics, University of Miami School of Medicine, and Director, Regional Neonatal Intensive Care Center, Jackson Memorial Hospital, Miami.

"Myocardial Dysfunction Syndrome in Asphyxiated Newborns," Richard L. Bucciarelli, M.D., Assistant Professor of Pediatrics, Divisions of Neonatology and Cardiology, University of Florida College of Medicine, Gainesville.

SECTION ON DERMATOLOGY (SECTION II)

(Co-sponsored by Florida Society of Dermatology)

Saturday, May 6 — 8:30 a.m. to 12:00 noon

Gerald Weinstein, M.D., Miami
Program Chairman

Presentations by Residents in Dermatology

Guest Lecture — William F. Schorr, M.D., Department of Dermatology, Marshfield Clinic, Marshfield, Wisc.

First Wiley Sams Lectureship:

"Photo-Contact Dermatitis," W. Mitchell Sams, Jr., M.D., Professor of Dermatology, University of North Carolina School of Medicine, Chapel Hill, N.C.

Presentations by Residents in Dermatology

Luncheon and Scientific Dermatopathology Session — Tobias Funt, M.D., Ft. Lauderdale.

SECTION ON CLINICAL ONCOLOGY AND RADIATION THERAPY

(Co-sponsored by Florida Society of Clinical Oncology and Florida Radiological Society)

Saturday, May 6 — 9:00 a.m. to 10:30 a.m.

Ellen Sayet, M.D., Fort Myers
Program Chairman

"Present Concepts in the Treatment of Lymphomas," Rodney R. Million, M.D., Professor and Director, Division of Radiation Therapy, University of Florida College of Medicine and Shands Teaching Hospital, Gainesville.

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology)

Saturday, May 6 — 9:00 a.m. to 10:30 a.m.

Giacomo S. Guggino, M.D., Tampa
Program Chairman

"Retinal Detachment with Intraocular Lenses," Raymond J. Sever, M.D., Tampa.

"Six Millimeter Bimedial Recession in Large Angle Congenital Esotropia," G. S. Guggino, M.D., Tampa.

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY

(Co-sponsored by Florida Society of Plastic and Reconstructive Surgery)

Saturday, May 6 — Time to be Announced

S. Anthony Wolfe, M.D., Miami
Program Chairman

"Recent Advances in Craniofacial Reconstruction," Mutaz B. Habal, M.D., Associate Professor of Plastic and Reconstructive Surgery, University of Florida College of Medicine, Gainesville.

"Some Problem Cases in Facial Reconstruction and Their Solution," Residents from the Department of Plastic and Reconstructive Surgery, University of Florida College of Medicine, Gainesville.

"A Potpourri of Hard-Tissue Plastic Surgery," S. Anthony Wolfe, M.D., Miami.

"Recent Advances in Breast Reconstruction," Rob Zaworski, D.D.S., M.D., Resident, Department of Plastic Surgery, University of Miami School of Medicine, Miami.

"Recent Advances in Hair Transplantation," John Devine, M.D., Miami.

"Early Transplant Surgeons," Felix Freshwater, M.D., Resident, University of Miami School of Medicine.

SECTION ON NEUROSURGERY

(Co-sponsored by Florida Neurological Society)

Saturday, May 6 — 9:30 a.m. to 11:30 a.m.

Donald D. Sheffel, M.D., Hollywood
Program Chairman

Selected Topics in CAT Scanning

Speakers:

O. Frank Agee, M.D., Professor of Radiology, University of Florida College of Medicine, Gainesville.

Peter A. Livingston, M.D., Radiologist, Hollywood.

Freddie Gargano, M.D., Clinical Professor of Radiology, University of Miami School of Medicine, and Chief Attending Radiologist, Palmetto General Hospital, Miami.

SECTION ON SURGERY

(Co-sponsored by Florida Chapter, American College of Surgeons, and Florida Association of General Surgeons)

Saturday, May 6 — 9:30 a.m. to 11:30 a.m.

Arthur L. Trask, M.D., Boynton Beach
Program Chairman

"Multiple Systems Failures," Arthur E. Baue, M.D., Donald Guthrie Professor of Surgery and Chairman, Department of Surgery, Yale University School of Medicine, New Haven, Conn.

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation)

Saturday, May 6 — 10:00 a.m. to 12:00 noon

Charles J. Kurth, M.D., Orlando
Program Chairman

"Electromyography (EMG): Use and Abuse and Recent Advances," Ernest W. Johnson, M.D., Professor and Chairman, Department of Physical Medicine, Ohio State University College of Medicine, Columbus, Ohio.

National Board of Medical Examiners To Test Medical Assistants

The National Board of Medical Examiners has been retained to prepare the 1978 certification examinations of the American Association of Medical Assistants.

NBME is a nonprofit testing organization which prepares and administers medical and specialty board examinations. In 1976, it expanded into the allied health field.

The American Association of Medical Assistants, an organization of about 18,500 members, has certified more than 7,500 medical assistants in administrative and clinical fields since its first examination in 1963.

This year's examination will be offered in the spring and fall at more than 100 test centers.

Scientific and Educational Exhibits

Convention Hall

May 4-6, 1978

A-B "Scope of Plastic Surgery and Rejuvenation of the Aging Face" — C. Gary Zahler, M.D., Florida Society of Plastic and Reconstructive Surgeons.

C-D "Osseous Reconstruction of Acquired and Congenital Craniofacial Deformities" — S. Anthony Wolfe, M.D., Samuel Merkowitz, D.D.S., and Wilma Mane-Dickson, Ph.D., Craniofacial Anomalies Clinic, University of Miami.

E-F "Screening for Scoliosis in Florida Schools" — Joseph C. Flynn, M.D., William F. Enneking, M.D., Merlin G. Anderson, M.D. and Augusto Sarmiento, M.D., Florida Orthopedic Society.

G "Computerized Axial Tomography of the Spine"— Stewart Bakst, M.D. and Fredie P. Gargano, M.D., Department of Radiology, Palmetto General Hospital, Hialeah.

H "The Management of School Learning Difficulties"— Ronald J. Cantwell, M.D., Evelyn Orkney, M.A. and Carole Repensek, M.A., Cantwell Pediatric Achievement Center, Miami.

J "Comprehensive Hemophilia Care" — Eric Lian, M.D., Deborah Clark, DPNP, Lynn Siegel, ACSW, Robert Christensen, R.P.T. and Helen Murray, R.D.H., University of Miami Comprehensive Hemophilia Center.

K "Considerations in the Management of Common Pruritic Dermatoses" — Roy Stephens, M.D., Douglaston, New York.

L "Cardiac Catheterization and Coronary Angiography on an Out-Patient Basis" — Zachariah P. Zachariah, M.D., Holy Cross Hospital, Ft. Lauderdale.

M "Technique and Indications for Azillo-Femoral and Bifemoral Bypass" — R. Vijayanagar, M.D., Paul F. Eckstein, M.D. and Diego A. Bognolo, M.D., Tampa.

N "Noninvasive Evaluation of Peripheral and Cerebral Vascular Disease" — Jeff Raines, Ph.D., Ernest Traad, M.D. and Parry Larsen, M.D., Miami Heart Institute, Miami Beach.

O "TRH Stimulation Test: Clinical Uses and Special Applications" — Fuad S. Ashkar, M.D., Division of Nuclear Medicine, University of Miami.

P "Epidermoid Implantation and Nerve Root Herniation Syndrome Due to Improper Performance of Spinal Puncture" — Mason Trupp, M.D., Tampa.

Q "The Treatment of Myocardial Ischemia" — James R. Jude, M.D., R. Iyengar, M.D. and I. Boruchow, M.D., St. Francis Hospital, Miami Beach.

R-S "Ischemic Infarctions" — R. G. Schnell, M.D., W. N. Dickens, M.D. and J. B. Perry, M.D., Ft. Lauderdale.

T "Percutaneous Forceps Extraction of Retained Bile Duct Stones" — John P. Fotopoulos, M.D. and Joseph A. Caprini, M.D., Jacksonville.

U-V W-X "Harvey — Cardiology Patient Simulator" — Michael S. Gordon, M.D., Ph.D., University of Miami School of Medicine.

Y-Z AA-BB Programmed Instruction System/Wyeth AutoTutor™, Philadelphia, Pennsylvania.

CC "Real Time Ultrasound in the Evaluation of Cardiac and Abdominal Disease" — Aldo Serafini, M.D., Division of Nuclear Medicine and Ultrasound, University of Miami School of Medicine.

DD "The Noninvasive Diagnosis of Thrombophlebitis: A Challenge and Opportunity for Clinicians" — H. J. Roberts, M.D., Palm Beach Institute for Medical Research, West Palm Beach.

EE "Colonoscopic Surgery" — John P. Christie, M.D., South Miami.

FF "Florida Sudden Infant Death Syndrome Information and Counseling Project" — J. Robert Griffin, M.A. and Kathy V. McKnight, R.N., M.P.H., Florida Department of Health and Rehabilitative Services.

GG "Disability Under Social Security" — George M. Davis, M.D., Office of Disability Determinations, Orlando.

HH "Glaucoma Detection" — Florida Society for the Prevention of Blindness.

JJ "The Professional Medical Assistant" — Mrs. Jo Ann Lee and Mrs. Dorothy G. Pass, Florida State Society, American Association of Medical Assistants.

KK "It's Fun to Teach" — Florida Academy of Family Physicians and The Florida Council on Graduate Education for Family Practice.

LL "Family Practice, the 20th Medical Specialty" — Florida Academy of Family Physicians.

MM "The Community Hospital Education Program in Florida" — The Community Hospital Education Council.

NN "Combined Use of Square Scalp Grafts and Strip Grafts for Male Pattern Baldness" — John W. Devine, Jr., M.D., Claude Noriega, M.D., Frank Mergen, M.D., Felix Freshwater, M.D. and Charles McLaughlin, M.D., Miami.

OO "Pain and Suffering: A Neurosurgical Treatment"— Raul V. Rivet, M.D., Miami.

FLORIDA MEDICAL ASSOCIATION AUXILIARY, INC.
ANNUAL MEETING
MAY 3-5, 1978, DIPLOMAT HOTEL, HOLLYWOOD

PROGRAM

WEDNESDAY, MAY 3, 1978

9:00 a.m. - 5:00 p.m.	Registration for all state officers, chairmen, and County Presidents—Mezzanine Lounge Preregistration for House of Delegates—Mezzanine Lounge Tickets available for Awards and FLAMPAC luncheon, Registration desk.
10:00 - 5:00	Hospitality Room — Embassy Room East
9:00 a.m. - 11:00	Executive Committee Meeting — Suite of President/President-elect
11:00 - 2:00	Pre-Convention Board of Directors WORKING LUNCHEON, Mezzanine Theatre, for ALL STATE OFFICERS, Chairmen of STANDING AND SPECIAL COMMITTEES, AND COUNTY PRESIDENTS. ALL members are welcomed as guests.
2:00 - 5:00	"A New Dimension in Communications"—Verbal Communications, Inc., Dallas, Texas. Seminar preregistration $10.00 each. Check with Registration desk for availability. Limited. All physicians and wives welcomed.

THURSDAY, MAY 4, 1978

8:00 a.m. - 5:00 p.m.	Hospitality Room — Embassy Room East — Displays and refreshments. Visit FMA A Art Show in FMA Exhibit Hall.
8:00 a.m. — 3:00 p.m.	Registration — Mezzanine Lounge
7:30 a.m. — 8:45 a.m.	Complimentary Continental Breakfast for members of House of Delegates—Mezzanine Lounge. Badges only.
9:00 a.m. — 12:00	First Session House of Delegates. Delegates must be wearing badges and be seated by 9:00 a.m. Delegates not seated with their delegation by 9:30 a.m. will receive no voting ballots.
11:00 a.m.	"Learning to Deal With Grief" Guest: Ms. Mary Sharpe, R.N., HOSPICE
11:30 a.m.	Installation of Officers, Memorial Service.
12:00 noon	Awards Luncheon — Cafe Crista honoring Past Presidents of Fl Auxiliary, Presentation of Art Sh Awards, Peggy Wilcox Tropl Membership, AMA-ERF and Internatic Health Awards. Speaker — Rex Kenyon, M. Chairman of Board, AMPAC Musical Presentation — DIMENSI 20 — Director, Mr. Harold Bradley
2:00 p.m.	Second Session, House of Delega Mezzanine Theatre. Delegates wear identifying badges should be sea with their delegation by 2:00. Delega will not be admitted after 2:15 p.m.
2:00 p.m. - 3:00 p.m.	"When Enough is Not Enough," Mike Levis and Mr. Paul Newman.
3:00 p.m. - 4:30 p.m.	Reports of County Presidents
4:30 p.m. — 5:30 p.m.	The Impaired Physician. Physici and all members invited.

FRIDAY, MAY 5, 1978

7:30 a.m. — 8:30 a.m.	Post Convention FMA Auxili Executive Committee Meeting, Suit President/President-elect
8:30 a.m. — 5:00 p.m.	Art Show, FMA Exhibit Hall
8:00 a.m. — 12:00 noon	Hospitality Room — Embassy Rc East (Closed during FLAMP Luncheon)
2:00 p.m. — 5:00 p.m.	Hospitality Room
9:00 a.m.	Post Convention Board of Direc Meeting — Mezzanine Thea Orientation for all 1978-79 State County officers, Chairmen, memt and guests. Officers and Chairr please be ready to transfer all file new Board. Mrs. Byron Than 1978-79 President, Presiding.
12:15 p.m.	FMA A/FLAMPAC Luncheon Cafe Cristal/Les Ambassade Dining Room Address: Honorable Richard Schweiker (R-Pa.) U.S. Senate
6:30 p.m.	FMA President's Reception, Pools

Hostess Auxiliary ..... Broward County Medical Auxiliary
Convention Chairman ..... Mrs. Irving E. (Charlotte) Fixel
Convention Vice Chairman ..... Mrs. N. Harry (Liz) Carpenter
Art Show Chairman ..... Mrs. Ray (Ann) Murphy, Jr.

Florida Medical Association Auxiliary, Inc.

TWELFTH ANNUAL BENEFIT ART SHOW

Exhibit Rules and Regulations

Read Rules Carefully

. All entries must be original work.

. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.)

. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).

. Only one artist's name should be listed for each registration slip.

. A registration fee of $10 will be charged for each entry. Entry fees are tax deductible.

. All registration slips and checks must be sent in together no later than April 21, 1978.

7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at the Diplomat Hotel no later than 3:00 p.m. Wednesday, May 3. Shipped entries will be refused.

8. All entries must remain on exhibition until 3:00 p.m., Saturday, May 6. They MUST be picked up between 3:00 and 4:00 p.m., Saturday.

9. We will not be responsible for entries not picked up by 4:00 p.m., Saturday, May 6, 1978.

10. Doctors, their wives and children are eligible to enter. Entry fees will be donations to AMA-ERF, divided equally among Florida medical schools.

Kindly enter my registration to show in the Benefit Art Show.

Fee of $_____ for _____entries is enclosed. I agree to abide by the rules and regulations for exhibiting material in the show.

Name _____

Address _____

City _____ County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) applying to your entry (entries)

( ) A. Painting. Include any media in color: acrylic, oil, casein, collage, watercolor, pastel, etc.

Size: _____ (H) x _____ (W) To be hung on wall.

( ) B. Graphics. Include pen and ink, charcoal, photography, etc.

Size: _____ (H) x _____ (W)

( ) C. Crafts. Include sculpture, pottery, ceramics, mosaic, weaving, jewelry, etc.

Size: _____(L) x _____ (D) x _____(H)

( ) I am the son/daughter of a Florida physician. Age_____

Judges will give "Awards of Merit" and "Best in Show." An "Editor's Award," given by the Journal of the Florida Medical Association, will be used on the cover of a future issue of the FMA Journal.

A registration fee of $10 will be charged for each entry. Make checks payable to:

FMA-A Art Show
c/o Mrs. Ray Murphy, Jr.
1040 N.E. 27th Ave.
Pompano Beach, FL 33062

NOTE: It is most important to know the size of your art objects, paintings, etc., to enable us to display them more professionally. We will not be responsible for damage or loss of any entry.

REGISTRATION DEADLINE APRIL 21, 1978

Judging will take place beginning at 9:00 a.m. on Thursday, May 4, 1978.

Comprehensive Programs at Economical Rates . . .

The Florida Medical Association, Inc. Sponsors Insurance Plans For Your Added Protection

As a FMA member, you may be entitled to some excellent membership services — the Association-sponsored insurance package is one of the most valuable! The available five plans are intended to help provide you and your family with reliable insurance protection at economical premiums. They encompass a wide range of coverages to meet your varied insurance needs — from hospital or medical insurance, to disability or life coverage. FMA sponsors insurance plans for **your** protection which means they are professional, comprehensive programs which operate effectively in today's inflationary economy.

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INSURANCE FROM CNA

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Term Life Insurance Plan . . .

helps provide added security for your family. FMA members may purchase life insurance coverage up to $100,000. High-limit protection is also available for your eligible family members. All applicants must meet the underwriting requirements of the plan.

Income Protection Plan . . .

helps replace your lost income by providing benefits up to $1,950 per month if a covered accident or illness disables you and you can't practice medicine. All FMA members under age 60 are eligible to apply for this protection. All applicants must meet the underwriting requirements of the plan.

Catastrophe Hospital Plan . . .

helps protect you from the high costs of extended hospitalization. It pays 80% of your covered hospital expenses up to a maximum of $15,000, after your chosen deductible has been satisfied. All FMA members under age 60, and their eligible family members may apply for this protection. All applicants must meet the underwriting requirements of the plan.

Hospital Money Plan

essential hospital insurance protection. It provides high-limit benefits up to $100 a d when you or a covered member of your fan hospitalized due to covered accident or illn Double benefits are provided for hospitaliz due to intensive care treatment. Acceptan Guaranteed to all FMA members under ag and their eligible family members.

Overhead Expense Plan . . .

helps you maintain your practice and meet overhead expenses when you are totally dis due to a covered accident or illness. It pro benefits up to $5,000 a month for covered expenses. Eligible expenses even include insurance premiums. All FMA members un age 60 are eligible to apply for coverage. A applicants must meet the underwriting requirements of the plan.

Watch your mail for further details (including costs, exclusions, reductions) on these vital insurance plans offered by the Florida Medical Association. Or contact your insurance administrator:

Professional Insurance Management Company (PIMCO)
P. O. Box 40198
Jacksonville, Florida 32203
(904) 354-5910
WATS 1-800-342-8349

Limitations on Contributions to Corporate Retirement Plans

Howard G. Dunlap

In 1976 many physicians felt for the first time the impact of Section 415 which was added to the Internal Revenue Code by the Employees Retirement Income Security Act of 1974 (ERISA). This Section imposes new limits on deductible contributions to corporate retirement plans. For the physician earning high income, the new limits may have severely reduced the amount of earnings he was accustomed to sheltering from current taxation in his retirement plans.

Section 415 imposes both percentage and dollar amount limits. For a defined contribution pension plan, or for any combination of pension and profit sharing plans, the annual contribution for a participant cannot exceed the lesser of 25% of compensation or $25,000 plus cost of living adjustments (in 1977 this limit has been adjusted to $28,175).

For a profit sharing plan, the total deductible contribution cannot exceed 15% of the compensation of all participants. This has not been changed by Section 415. However, the amount allocated to any participant cannot now exceed the above limit (the lesser of 25% of compensation or $28,175 in 1977).

For a defined benefit pension plan, the retirement income to be provided by the plan cannot exceed the lesser of 100% of the participant's average pay for his three highest paid years or $75,000 per year plus cost of living adjustment (in 1977 the maximum retirement income has been adjusted to $84,525 per year). The deductible contribution each year to this kind of plan is the amount which an actuary determines as necessary to fund the projected benefit.

A physician can maximize retirement contributions under Section 415 by adopting both a defined contribution pension plan and a defined benefit pension plan. The sum of the contributions and benefits provided by this combination is restricted to 140% of the limits imposed on each kind of plan. In other words, one of the two plans may provide for contributions or benefits equal to 100% of the limits for that kind of plan, and the other they provide for contributions or benefits equal to 40% of the limits for its kind of plan.

Some practical experience with these new limits suggest the following conclusions:

(1) For a physician under age 45, a defined contribution pension plan or a combination of pension and profit sharing will permit larger contributions. For a physician over age 45, a defined benefit pension plan will permit larger contributions.

(2) If a physician selects a defined contribution approach with annual contributions thereby limited to 25% of compensation or $28,175 in 1977, a combination of pension and profit sharing will usually make more sense than a single defined contribution pension plan. The reason is that whether it is just a pension plan or a combination of pension and profit sharing, the overall limit on contributions is exactly the same. But a combination of pension and profit sharing offers far more flexibility since profit sharing contributions, unlike pension contributions, are always optional and may vary in amount from year to year at the discretion of the corporation's directors.

(3) For the physician earning high income, the use of two pension plans to maximize contributions

should be considered. The size of the contribution permitted by such a combination can more than offset any additional expense involved in maintaining two pension plans.

For example, a young physician with a salary from his corporation of $100,000 or better can combine a maximum defined contribution pension plan with a 40% defined benefit pension plan to create a deductible contribution for himself of $35,000 to $40,000 per year, depending on his age.

An older physician with a salary in the $100,000 range can combine a maximum defined benefit plan with a 40% defined contribution pension plan to create deductible contributions for himself as large as $55,000 to $65,000 per year again depending on age.

As the foregoing indicates, it is still possible to make very substantial contributions to corporate retirement plans. Section 415, however, dictates an entirely new set of strategies in designing optimal plans. Fortunately, it is usually a simple matter to modify existing plans and, if necessary, add an additional plan to take fullest advantage of this new Section of the Code.

This article is the second in a series submitted by the Florida Medical Association's Council on Medical Economics, James F. Richards Jr., M.D., Chairman.

Mr. Dunlap is an associate with Gordon Rainey and Associates representing New England Life Insurance Company in Jacksonville.

Medicaid Fiscal Agent

SDC Integrated Services, Inc. became Medicaid Fiscal Agent for the State of Florida in January 1978. As Fiscal Claims Agent we are responsible for receiving, processing, and paying Medicaid provider claims. As we stated in a recent provider newsletter, an initial backlog of claims has developed resulting from our key punch operator staff not having reached their maximum production capacity. We are taking all possible steps to eliminate this backlog condition at the earliest possible time, including overtime, weekends, and subcontracting.

There are areas in which you can help us to pay your claim faster:

- **Many physician claims are received with incorrect or no procedure codes. Please request your billing clerk always to use the correct procedure code when the clerk is completing the Medicaid invoice form.**
- **Some invoices are received that are not signed. If an invoice is not signed (you may designate your secretary or billing clerk to do this), the invoice must be returned, thereby delaying the payment to you.**
- **Please do not submit an adjustment to us if we have indicated to you that we will correct a particular claim. Some claims payments were reduced from the allowed amount of $9.50 to an incorrect amount of $8.80. We have corrected our billing programs to pay the correct amount on subsequent runs.**
- **Please request your billing clerk to prepare the invoice legibly. The data entry clerk who enters your invoice will attempt to read the invoice as carefully as possible. Poor penmanship may cause the clerk to make mistakes.**

Our Claims Inquiry Stations are usually extremely busy between the hours of 8:30 a.m. to 12:00 noon and 1:00 p.m. to 4:30 p.m. If you have had trouble reaching us, try calling between the hours of 7:30 a.m. to 8:30 a.m., 12:00 noon to 1:00 p.m., and 4:30 to 6:30 p.m. Our experience has been that these are the hours of little telephone traffic and it may be easier to reach us during those periods.

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Book Reviews

Book Review Editor — F. Norman Vickers, M.D.

Diagnostic Pathways in Clinical Medicine: An Epidemiological Approach to Clinical Problems. by B. J. Essex, M.B., MSc. MRCP. 173 pages. Price $9.95. New York, Churchill Livingston, 1977.

I find several problems with this paper bound book. While "the usefulness of this book will not be limited only to medical workers in developing countries, it should be valuable reading for those in temperate climates who aspire to serve in developing countries of Africa." (Foreword). The author takes only the epidemiological data for Tanzania and constructs 53 flow charts which cover the major signs and symptoms presented by patients in Tanzania, asserting that by using the flow charts, medical students or paramedical personnel can "make accurate diagnosis of clinical problems in under three minutes per patient."

As a physician who works in a tropical area and has a very large patient load, I find nothing in this book to either convince me of the usefulness of making a diagnosis in three minutes nor of utilization of the book in other areas of my daily practice.

This book just makes medicine seem too easy. There is too much ambiguous terminology used and I gave up counting the instances after the first ten. One good example is the use of "nutritional anaemia" where the author plainly means a hypochromic microcytic anemia and the use of "Hookworm anaemia" to designate the same anemia as produced by *Necator americanus* infestations. The only reference to nutritional deficiencies is in connection with the Protein-Calorie Malnutrition syndrome. The multiple vitamin and mineral deficiencies found throughout Central and South America are not mentioned at all in this text.

The author wrote this book to help ease patient care in areas of Tanzania where one medical student must see 150 to 200 persons daily. Certainly there is some value in viewing the epidemiology of the area and connecting it with the signs and symptoms of patients, but is this teaching good medicine? The three minute diagnosis takes the personal contact out of the medical relationship; something essential in the total caring for the patient. My experience with the Shuar and Achuar tribes of the upper Amazon Valley demonstrates that even for primitive peoples the "chat" before the physicial, the explanation of what is wrong, and the manifestation of caring about the person are indispensable if one is to heal well.

If you are going to Tanzania and want an idea of the medical problems there, the flow charts will help. I do not recommend the book to anyone else.

Thomas Brown, S.D.B., M.D.
Taisha, Ecuador

Dr. Brown is Medical Director, Centro Medico San Jose, Taisha, Ecuador.

How to Read an ECG, by Margaret G. Blowers, R.N., B.S.N., and Roberta J. Smith, R.N., M.Ed. Edited by Herbert H. Butler, M.D. Price $4.95. 110 Pages. Illustrated. Medical Economics, Oradell, N.J., 1977.

This is the fifth printing, in steno book form, of material originally presented in RN magazine and is directed primarily to nurses and other health workers. The spiral binding allows it to be opened flat for easy reference. William Burke, a medical illustrator from Jefferson Medical College, is responsible for the superb art work.

The topics covered include the normal ECG and related heart anatomy, ECG leads, arrhythmias, heart blocks, and myocardial infarction. Treatment of the various conditions is discussed without differentiating between those a nurse (or other health worker) should or should not handle. For instance, on p. 16 under the "Treatment of PAT" (paroxysmal atrial tachycardia) the author states "Since cardiac arrest can occur with any mode of treatment . . ." certain measures such as an ECG machine attached to the patient, a defibrillator, etc., must be at hand. Then, if simple measures do not help, right carotid massage for several seconds is

advised. No admonition or caution is offered concerning who should apply the massage or treat complications, such as stroke, which may develop. Not all health professionals, including certain physicians, RNs, LPNs, and EMTs, would necessarily have the background or interest in taking a complete history from the patient regarding possible transient ischemic attacks or be able to examine the neck for bruits, etc. Nevertheless, with this warning in mind, the volume remains a unique and handsome basic contribution to the literature of electrocardiography. It will prove very useful to the group for whom it is intended.

Irwin R. Callen, M.D.
North Miami Beach

Dr. Callen is a member of the Board of Directors and Honorary attending physician at the Miami Heart Institute in Miami Beach.

Review of Medical Physiology, 8th Edition, by W. F. Ganong, M.D. 565 Pages. Illustrated. Price $12.50. Lange Medical Publications, Los Altos, California, 1977.

The author has revised the *Review of Medical Physiology* for the 8th edition and, in so doing, has brought this excellent volume completely current. It is difficult to find fault with a volume as complete and as carefully written as this one is. Although the discussions in each chapter are by no means meant to represent indepth coverage, they do provide an excellent basic review of the physiology involved and a helpful correlation with common clinical problems. The book is organized into several broad categories, each of which is broken into many individual discussions of the functions involved. The category covering endocrinology and metabolism is especially well written and offers superb clinical correlations. If one were to find any fault with this volume at all, it would be in the fact that the references, although quite up-to-date and adequate, are placed at the end of each major section rather than at the completion of the individual chapters. This volume is reasonably priced and should be an invaluable resource to houseofficers in training and ought to provide a good basic reference for practicing physicians.

Bradley M. Rodgers, M.D.
Gainesville

Dr. Rodgers is Associate Professor of Surgery and Pediatrics, Division of Pediatrics, University of Florida College of Medicine, Gainesville.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Labor & Delivery, An Observer's Diary by Constance A. Bean with an introduction by Gerald Cohen, M.D. 203 Pages. Price $7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

The Nervous System by William F. Ganong, M.D. 226 Pages. Illustrated. Price $8.00. Lange Medical Publications, Los Altos, California, 1977.

Handbook of Pediatrics by Henry K. Silver, M.D., C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 723 Pages. Price $9.00. Lange Medical Publications, Los Altos, California, 1977.

Nothing to Fear, Coping With Phobias by Fraser Kent. 204 Pages. Price $7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Human Nervous System by Gary B. Dunkerley, Ph.D. 216 Pages. Illustrated. Price $5.50. F. A. Davis Company, Philadelphia, 1977.

Clinical Cardiology by Maurice Sokolow, M.D. and Malcolm B. McIlroy, M.D. 659 Pages. Illustrated. Price $16.00. Lange Medical Publications, Los Altos, California, 1977.

Life and Death in the Modern Hospital PATIENTS by Polly Toynbee. 279 Pages. Price $8.95. Harcourt Brace Jovanovich, New York, 1977.

Medical Aspects of the Imported Fire Ant by Robert B. Rhoades, M.D. 75 Pages. Illustrated. Price $4.75. The University Presses of Florida, Gainesville, 1977.

Occupational Diseases: A Syllabus of Signs and Symptoms by E. R. Plunkett, M.D. 352 Pages. Price $22.50. The Barrett Book Company, Stamford, Connecticut, 1977.

Current Medical Diagnosis & Treatment by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1098 Pages. Price $17.00. Lange Medical Publications, Los Altos, California, 1978.

Diabetic Menus, Meals and Recipes by Betty M. West, revised by Nancy Greene Eash, M.S., R.D. 194 Pages. Price $7.95. Doubleday & Company, Inc., New York, 1978.



HILL CREST HOSPITAL — For Intensive Treatment of Psychiatric Disorders

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Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals. Alabama Hospital Association, Birmingham Regional Hospital Council.

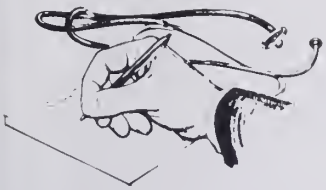
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Others Are Saying

Doctor of the Day — Why Not You?

Stepping down from the Speaker's podium of the Florida House of Representatives after being introduced as the Doctor of the Day, I was abruptly accosted by a Volusia County representative wanting to know my feelings on a specific medical problem and why my specialty had not been more vociferous in its support of a certain bill. On that day in the spring of '75, I could not fully discuss the subject as I was not prepared to do so. I had decided to be Doctor of the Day for the fun of it and had no idea what it could entail.

But this incident and my subsequent sitting on the Floor of the House with our Polk County Representatives while the session was in progress, made me realize the opportunity that we physicians have in being Doctor of the Day. Except for the Minister of the Day and various pages and runners, essentially no other person is allowed on the Floor of the House while it is in session. In one large arena, the Doctor of the Day has the opportunity to talk to any or all members of the House, individually, about anything or any bills he desires. No lobbyist, groups, other factions or people have such an opportunity available to them!

So in the spring of this year, I was much better prepared when I again volunteered to be Doctor of the Day. Not only had I made an effort during the year to keep up with the bills to be introduced, but I also went to the FMA office next to the Capitol where the staff eagerly briefed me on the current status of these bills and the FMA stand on them. Then sitting with our Polk County Representatives, I freely discussed a number of bills offering specific opinions; and, I developed a rapport with our representatives which was further enhanced at dinner that evening. They talked but they also listened. And they will listen if we make the effort to talk with them. Both my wife and I found this to be a rewarding, interesting, educational and genuinely fun experience. And I think more Polk County physicians should take advantage of this unique opportunity.

The medical aspect is primarily availability. Unless an emergency arises, most of the problems are minor and can be handled by the nurse, with the physician only seeing the patients he feels need to be seen. One night's lodging is provided. Meals are not provided.

But perhaps you don't want to go to North Florida. I tell you that in the spring, Tallahassee is one beautiful city abounding with activities that the whole family can enjoy. We have tried it with and without our kids; and, I must say that our boys enjoyed it as much as we did. Observing the mechanics of our State Government has been an educational experience for all four of us. Also, we have thoroughly enjoyed the Tallahassee area with such points of interest as: Tallahassee Junior Museum — a working early American farm with trails in the woods and animals, fenced in their natural habitats; Florida State University with its spring sports and cultural activities; Springtime Tallahassee — a several week celebration culminated with a parade, arts and crafts show and home tours; golf and tennis at the various parks and clubs or at Killearn Country Club (which is a superb place to stay if you have a car as they have excellent motel, restaurant, golf and tennis facilities); Tallahassee Open Golf Tournament; a ride around the city admiring the trees and homes; or, a leisurely ride in the surrounding countryside finding one's way to Bradley's Country Store, famous for its sausage.

Some of this can be incorporated to make it a most enjoyable trip but with a specific purpose of not only providing a service for our Legislators, but also to develop an understanding of and become involved in our State Government — to help get across our point of view. It is a pleasant and enjoyable way to get involved.

SO — WHY NOT YOU AS DOCTOR OF THE DAY?

Ben M. Crowder, M.D.
Winter Haven

Reprinted from The Imperial Polk County Medical Association Bulletin, November 1977.

Socialized Medicine
Beware New Boondoggle From HEW

Okay, folks, we're going to reduce the cost of medical care. The next time your doctor recommends treatment, whether it's surgery or drugs, you come to me and I'll decide if you should have it.

I'm not a doctor, of course, and I know beans about medicine or about you, but health care costs are rising and somebody has to decide which treatments are really necessary and which ones are cost-efficient.

Now if you think that suggestion is silly — and I do — then you'd better take pen in hand, as they used to say, and write your beloved congressmen and tell them you don't want national health insurance.

The reason is that what these yahoos in the Health, Education and Welfare Department have in mind for you is exactly that notion: that someone else besides you and your doctor shall decide what kind of medical care you will get.

HEW, for example, is busily proposing that only hospitals which meet its criteria shall be allowed to buy the equipment necessary for open heart surgery, high energy radiation therapy for cancer and computerized tomography, a device which takes three-dimensional x-ray photos.

HEW thinks that if there are not enough patients to justify the cost — in HEW's opinion — then hospitals should be forbidden to purchase this equipment.

Suppose HEW decides that unless there are 300 people who need open heart surgery, it's not feasible to have the facilities. If you happen to be one of the 298 who need it, tough beans. You can travel to the nearest HEW-approved facility at your own expense....

So perhaps a few thousand people die who could have lived. You can't make an omelet without breaking eggs. That's the attitude these stupid, power-hungry, over-zealous elitists have toward us common folk.

If you'd rather entrust your health care decisions to Joe Califano, a Washington lawyer who was the architect of LBJ's Great Society Welfare Fiasco, than to your own doctor, then you'll get the kind of health care you deserve. That is to say, your ailments will be cured about as efficiently and expensively as poverty is "cured" by the Great Society.

How often does it have to be said? There is no such thing as a free lunch. Always look a gift horse in the mouth. The government is not Santa Claus, it's Fagin. Government grants all come with strings. Socialized medicine stinks.

People are so often conned. They think: Gee, with national health insurance, no matter what happens to me, I can end up with a doctor and a hospital bed. Well, anybody in a state prison can make the same statement. The important questions you should ask are: What kind of hospital? What kind of doctor? And at who's expense?

I've lived and worked in England and their national health program is for the birds. The better doctors, many of them, fled the country; the hospitals are over-crowded and under par and it's still the rich who get the best care available.

In short, it was a con. Now, despite the obvious failure of that system to deliver what it promised, the Washington crowd is trying to peddle the same system to us.

To peddle it, the propagandists are trying to create in the public mind an image of doctors as calloused, incompetent and greedy. Unfortunately some doctors contribute to the cause by being calloused, incompetent and greedy, but public policy should never be based on exceptions. Most doctors die of overwork and if you measure their return on their investment, they'd have gotten richer selling cemetery lots.

We should reject appeals to envy. What do I care what my doctor's annual income is? All I care about is that when I ask him for $15 worth of advice, he's spent 10 years of hard study in order to give it to me and that I stay healthy enough to contribute only a minimal amount to whatever his total income is.

Under the present system, that's the way it works. We can choose our doctors, choose to take their advice or disregard it, and expect, if we need it, they'll have the best and most expensive equipment regardless of what the government thinks.

Before you let Califano pawn another system off on you, you'd better take stock of what you've got to lose.

Charley Reese
Orlando

Reprinted from the Pensacola News Journal, December 8, 1977. Mr. Reese is a syndicated columnist for the Sun Belt Syndicate, Inc.

The Cult of Specialism

Somewhere during the last generation, our society has developed the idea that if one is not a specialist he must be a second-class person. As a result, specialization has been carried to ridiculous extremes and has been so diluted and prostituted as to be now almost meaningless. And yet, by upgrading the standards, it is a valuable and worthwhile concept and thus, needs a new look and a fresh definition. The foregoing applies to every field of work or study, but when the term "Specialist" is used, the first image to be conjured up is that of a Doctor. Since we are doctors, perhaps we are the ones who must begin to examine specialization and attempt to restore some real significance to the term. Since, in this day, almost all doctors are specialists (only a few, rather old ones, disclaim this title) this task should be either very easy or very difficult.

As a beginning, how does the dictionary define Specialist? *The American Heritage* says "a. One who has devoted himself to a particular branch of study or research. b. A physician certified to limit his practice to a specified field." Well, if that's all there is, what's the problem?

The problem that I see is one of unfulfilled expectations. First, on the part of the patient and, second, on the part of the specialists. In my opinion, there are too many specialists and, also, too many specialists who shouldn't be specialists. The term should denote just what it says — someone doing something special. Instead, we find most of them performing rather common place functions. Let's start by reserving the term for those who by virtue of exceptional training, skill, or brilliance can do things that very few others can do. There certainly should be a difference between "practice limited to—" and "specialist in—"

How did this situation develop? Looking back on my own career, the pressures to specialize began in medical school. There was no room for the student to doubt. The really worthwhile physicians were those specialists on Medical School faculties. Somewhat behind them, but still acceptable, were those who were certified by a Specialty Board but who chose to practice outside the Ivory Tower. Somewhere down toward the bottom was the GP, who did his best, but — I think that these attitudes still persist, although a little more subtle and not confined to the Medical schools. (Many of the graduates have taken them out with them and have made their own classifications.) The only motive I have ever been able to find to explain these attitudes is self-aggrandizement. The only way to become a specialist is to take a Residency. A Residency program has to have a professor. The bigger the program, the bigger the professor. The bigger the program, the more likelihood of large grants. A little empire develops and any incursions into its territory are resisted unto the death. The result is more specialists who may not wind up doing what they want to do, or what they are trained to do.

So much for the educators' part of the system. What about the student? Why does he want to be a specialist? Well, he's been convinced that he doesn't wish to be a second-rate practitioner. But there is more. He still envisions specialization in the classical image. As he begins his training he sees the superstar picture of him who solves the problems no one else can handle; who sees few patients each day because he must spend so much time with each one (and besides there aren't all that many who need his expertise); and finally, because he has so much to offer, his fees are large. When he is finally certified and cast out to specialize he finds the patients who need him aren't that numerous, the fees aren't that large, and he is treating patients for which he is overtrained.

Now the final actor in this drama of unfulfilled expectations is the patient. He, also, is the victim of the cult. If he doesn't have a specialist to treat him or his family, he is being deprived of first-rate care and, yet, he still wants that specialist to be "Good Ole Doc." He not only wants, but expects him to be available at all times for scarcely imaginable topics of consultation, whether in his limited field or not.

Is it any wonder then that there is ambivalence in us all. We want, and we don't want. The patients don't want and they want. The professors just want things their way. I see a few individuals in our midst who are honestly specialists by any standards, but most of us are merely certified to limit our practice. I think it is time that we became honest with ourselves and our patients and demand honesty from academia. I think we should decide whether or not we wish to go on with this fragmented medical care by innumerable "certified limited practitioners" or whether we should attempt to restore the true meaning to specialization and make it possible for true specialists (very few) to function as such.

From the standpoint of economic necessity, specialists are now broadening their fields to encompass patients and conditions that don't really

require their specialized training. This may not be all bad, although expensive and a bit of a waster. What does sadden the heart is when a specialty extends its boundaries, erects fences, and jealously guards them. In essence it becomes a "Dog in the Manger." There is no way that this can be justified as improving the quality of medical care, or providing better care for the public.

If any person herein sees his portrait, it is completely intentional.

James K. Conn, M.D.
Tallahassee

Reprinted from The Capital Medical Society Newsletter #41, August 1977. Dr. Conn is the Newsletter Editor.

We Need The AMA

The American Medical Association, official spokesman for organized medicine, was founded in 1847. Throughout the years it has represented us well, primarily by responding to crises which have affected us, the physicians of America.

When the concept of Medicare reared its ugly head, organized medicine, through the AMA, helped keep it from being a reality for over twenty years. The AMA pointed out the enormous cost that such a program would require, and what a many-headed bureaucratic monster it would be. But it offered no alternative for the social problem that Medicare addressed.

These days there is another such crisis, which many feel will inevitably be a reality: some form of National Health Insurance. This time the AMA has taken a more realistic approach to the problem. If National Health Insurance is inevitable, then it is imperative that we, the physicians of America, have some significant input into how the program will be planned, with strong emphasis on the private sector way of doing things.

This kind of approach requires a lot of money. AMA dues are now $250.00 a year, which is used to pay for the many AMA activities and services for members emanating from the AMA Chicago office, and for the expensive and necessary lobbying that is and must be done in Washington for this problem as well as to watchdog the multitude of regulations proposed in the Federal Register.

It is the individual doctor's responsibility to carry his/her share of the economic load. The Duval County Medical Society has 752 members, 37% of whom do not belong to the AMA. The cries of "They never do anything for us" or "The dues are too high" are far too common, yet erroneous. If we don't have input into National Health, I assure you that the optometrists, podiatrists and especially the chiropractors will. When these groups need money, a $1,000 assessment is not unheard of. When organized medicine needs a war chest, its $50 to $100 assessment is moaned and groaned about, and even used as an excuse to drop out. Yet many of these same AMA critics think nothing of blowing a similar amount on a day's outing in the family power boat, or an evening at the Country Club. Annual dues at most of the Jacksonville area country clubs, all of whom have large doctor representation, are higher than membership in the American Medical Association. It is a matter of priorities, but we need to do more this time than just sit back and say "look what they are doing to us again!"

With this preamble, I urge each physician to join the AMA, and to channel some of his/her hard earned dollars to where they can best help the cause of American medicine.

Guy T. Selander, M.D., President
Duval County Medical Society
Jacksonville

Reprinted from Jacksonville Medicine, April 1977.

Choosing Priorities

We establish priorities for ourselves and others all the time. We set them when we decide that abortion is all right because the potential life is not so valuable as the quality of life of family and society.

Public health officials and physicians, given limited budgets, are continually called upon to make hard decisions. Should they save congenitally defective babies, expand family planning services or invest in a health program for school children? Which diseases should be given highest priority? Which groups should get chest x-rays and vaccinations?

It is estimated that sixty thousand people die annually in the United States because their kidneys no longer function properly, individuals whose lives could be prolonged by periodic dialysis or transplanted kidneys. With limited numbers of donors and centers for transplantation, and with too few dialysis centers to serve more than a fraction of the afflicted, which lives to be saved?

Which of the many victims of untreatable heart disease (estimated at eighty thousand annually) should get a heart transplant? If mechanical hearts, which may be perfected during the lifetime of many of us, become widely available, what choices will society then be called upon to make? Should an artificial heart be implanted in everyone who needs and wants one, on request of the physician? Or should only those who can be useful and productive again be helped to continue to live?

The cost of life-prolonging medical advances presents another difficult choice. Resources for medical needs and medical research are not unlimited. A single heart transplant costs $20,000 to $50,000; a kidney transplant approximately $20,000. Congress spends millions annually for medical research. Society has a right to ask — and scientists have an obligation to answer — such questions as, what are the alternatives? What are some of the other uses to which these same funds might be put? Is the choice between research on an artificial heart for the old and preventing rheumatic heart disease in the young? Between dialysis units and neighborhood health centers? How many individuals could be rehabilitated with glasses, hearing aids, or dental care for the cost of one heart transplant or one kidney unit?

In making choices we must remember that medical advances that cost millions of dollars in their research and experimental stages have resulted in making life possible or better for countless individuals, and that while the cost of services to the earliest beneficiaries of these advances was sometimes high, it was greatly reduced as techniques were perfected and adequate supplies became available.

In establishing medical priorities we are confronted by a number of profound social and moral considerations. Is it desirable to keep increasing the life span of the general population? To what limit? If we could make it possible for people to live to be well over one hundred, should we? Would the added years be fulfilling and productive for the individual, his family and society? Or would we simply be adding to the unhappiness of an ever increasing number of people and aggravating the population crisis?

We must establish priorities within the field of medicine. The magnitude of the problems demands continuing comprehensive studies and intelligent choices in adjusting priorities for the allocation of public funds. The series of actions that are finally taken and the quality of continuously evolving public policy will depend on the extent to which not only physicians but citizens understand the issues and choices before them.

The quality of future human life depends on the priorities society chooses now and in the years immediately ahead. Too often in the past decisions were made because of the drama and challenge of scientific experimentation and for reasons of political expediency. Too often in the past decisions were made because no one had the courage to protest.

Medicine must establish priorities and have the courage to make choices in the existing biological and medical problems and not make decisions because of pressure by special interests.

Edward Pedrero Jr., M.D.
Tampa

Reprinted from "The Editor's Column" in the Hillsborough County Medical Association Bulletin, March 1977.



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Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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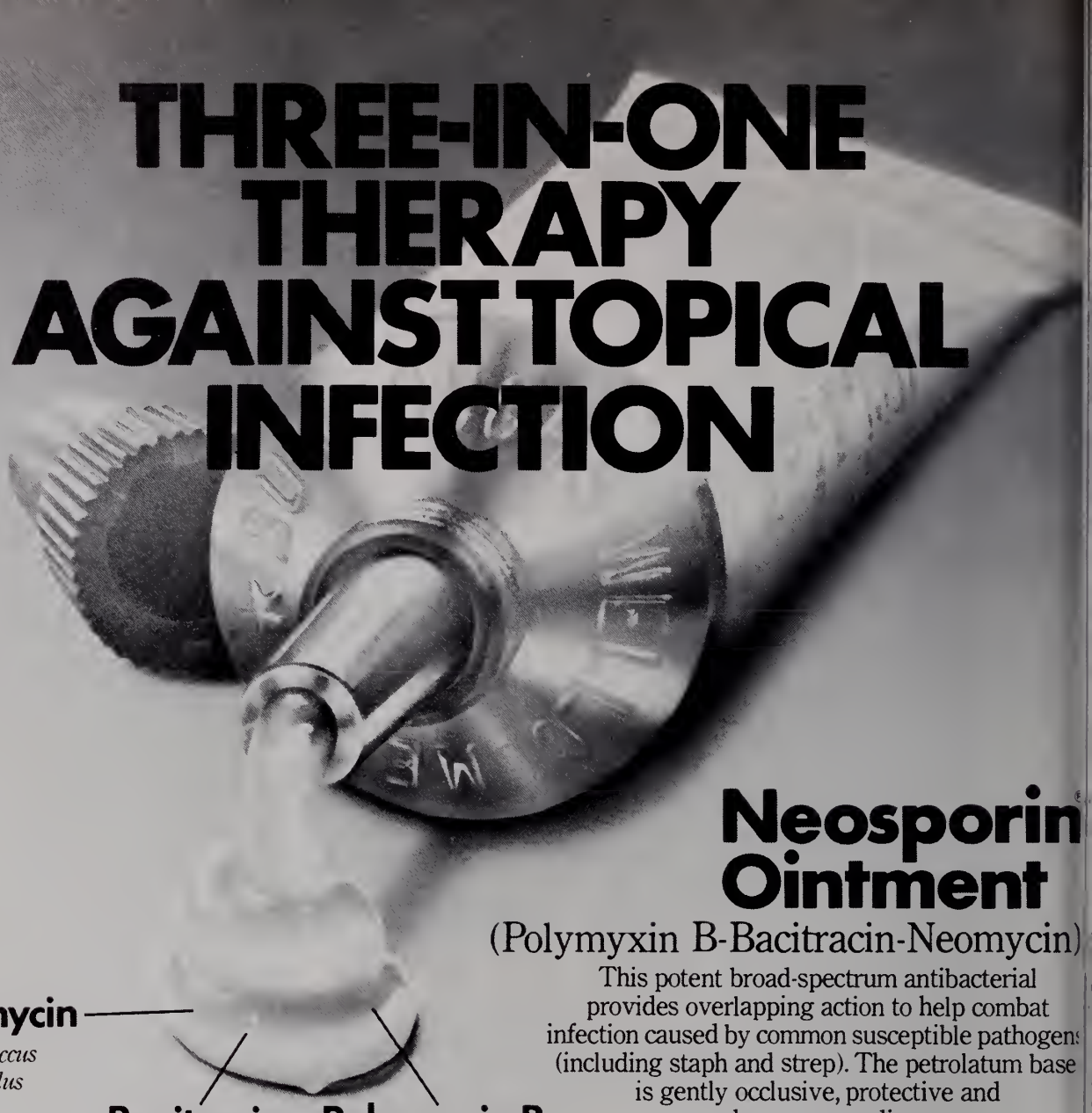
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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

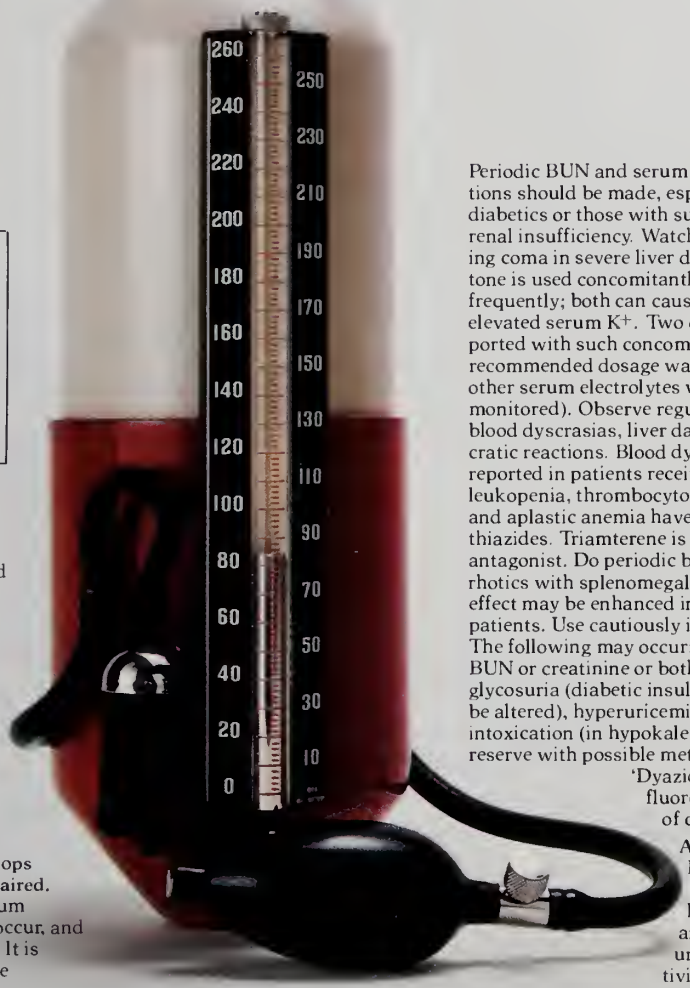
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Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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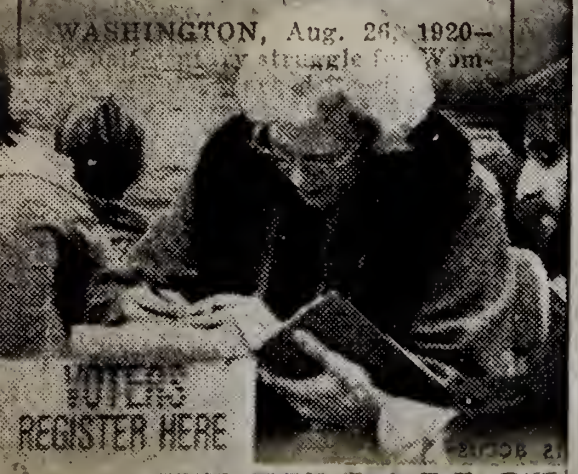
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WASHINGTON, Aug. 14 The Social Security Bill, p a broad program of unemp insurance and old age p and counted upon to bene 20,000,000 persons, became day when it was signed b dent Roosevelt in the pre those chiefly responsible ting it through Co

Mr. Roosevelt cal "the cor erstone which is being me s c ple

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the Draf Ends No

NEW WORLD HOPE

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HISTORIC LANDMARK

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"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST, N W, WASHINGTON, D C 20005

MEETINGS

Approved by the FMA Committee on Continuing Medical Education

MAY

104th FMA Annual Meeting Scientific Program, May 3-6, Diplomat Hotel, Miami Beach. For information: Henry M. Yonge, M.D., P.O. Box 2411, Jacksonville 32203.

Second Annual Symposium on Underwater Medicine, May 4-8, Miami.*

Noninvasive Diagnostic Techniques in Family Medicine — The Aging Patient, May 5, Miami Beach.+

Seizure Disorders, May 5, VA Center, Bay Pines. For information: John C. Gallagher, M.D., Chairman, Education Committee, VA Center, Bay Pines 33504.

Newer Clinical Perspectives in the Management of Myocardial Infarction and Coronary Artery Disease, May 5-6, Barefoot Beach Inn/Sheraton Motor Inn, Panama City Beach. For information: Ernest G. Haslam, M.D., 258 S. Highway 79, Panama City Beach 32401.

T.A. 101 Course, May 6-7, Finisterra Apartments, Shalimar. For information: John S. Waldo, 30 Eglin Parkway S.E., Fort Walton Beach 32548.

Oncology in Community Practice, May 8, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Boulevard., Inverness 32650.

Post-Convention Seminar and Diving Program, May 8-11, Miami.*

Fluid and Electrolyte Balance for the Practicing Physician, May 8-12, Holiday Inn, Navarre Beach. For information: R. Douglas Collins, M.D., 1000 West Moreno St., Pensacola 32501.

Orthopedic Seminar, May 11, Mercy Hospital Conference Center, Miami. For information: James Jude, M.D., 3663 South Miami Ave., Miami 33133.

Pars Plana Vitreous Surgery — The Miami Technique, May 11-13, Miami.*

5th Annual Neonatal & Pediatric Respiratory Care Seminar, May 12-13, Don CeSar Beach Resort Hotel, St. Petersburg. For information: William H. Schmid, M.D., 801 6th Street, S., St. Petersburg 33701.

Update: Gynecological Endocrinology, May 13, Bay Harbor Inn, Tampa. For information: Robert W. Yelverton, M.D., 4700 N. Habana, Tampa 33614.

Clinical Family Planning for Physicians, May 15-16, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th St., Jacksonville 32209.

***For information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

Family Medicine Update — 1978, May 18-21, Miami.*

Laparoscopy Course, May 22-23, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

7th Family Practice Review, May 22-26, Gainesville Hilton, Gainesville.**

JUNE

Review Course for Certification in Internal Medicine, June, Miami.*

The Private Practice of Psychiatry, June 8, Mercy Hospital, Miami. For information: Bernard Tumarkin, M.D., 3663 South Miami Ave., Miami 33133.

Bascom Palmer Eye Institute Alumni Meeting and Seminar, June 9-11, Miami.*

Cardiology Weekend: Current Approaches to Clinical Problems in Cardiology in Our Community, June 9-11, Sonesta Beach Hotel, Key Biscayne.*

A Day of Hypertension in Spanish, June 10, Hotel Omni International, Miami.*

Florida Suncoast Pediatric Conference, June 12-14, Sheraton Sand Key, Clearwater.+

Coronary Disease, Exercise Testing and Cardiac Rehabilitation, June 23-25, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

Fifth Annual Postgraduate Seminar in Respiratory Care, June 23-25, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Seminar for Intensive and Critical Care Personnel, June 23-25, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Laparoscopy Course, June 26-27, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

JULY

Examination of the Arterial System, July 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 522 West Highland Boulevard, Inverness 32650.

Clinical Family Planning for Physicians, July 17-18, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Laparoscopy Course, July 24-25, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

AUGUST

Clinical Electrocardiography and Arrythmia Management, Aug. 11-13, Hyatt House, Orlando. For information: William E. James, Ph.D., 64 Inverness Drive, Englewood, Colorado 80110.

Initial Management of the Pediatric Emergency, Aug. 23-27, Playboy Resort Hotel, Lake Geneva, Wisconsin. For information: Emergency Medical Services Symposia, Inc., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

Laparoscopy Course, Aug. 28-29, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

SEPTEMBER

Transient Ischemic Attacks: The Computerized EEG, September 11, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.

Fifth Annual Cardiovascular Symposium, Sept. 14-15, Hilton Inn, Gainesville. For information: Howard W. Ramsey, M.D., P. O. Box 13494, Gainesville 32604.

Anesthesiology Review and Update, Sept. 15-17, Sonesta Beach Hotel, Key Biscayne. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Clinical Family Planning for Physicians, Sept. 18-19, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Laparoscopy Course, Sept. 25-26, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

OCTOBER

Laparoscopy Course, Oct. 25-26, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

NOVEMBER

Adolescent Medicine, Nov. 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Clinical Family Planning for Physicians, Nov. 13-14, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Laparoscopy Course, Nov. 13-14, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

DECEMBER

7th Annual Refresher Course for Nurse Anesthetists, Dec. 1-3, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Laparoscopy Course, Dec. 11-12, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

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28th ANNUAL
POSTGRADUATE SEMINAR

NUTRITION — USES AND ABUSES

WEDNESDAY, THURSDAY AND FRIDAY
MAY 10, 11, 12, 1978

COURSE DESCRIPTION:

This course is designed to provide a comprehensive review of the nutritional assessment and care of hospitalized patients. The program is structured to provide basic and practical nutritional orientation for all medical specialties as well as nurses, dietitians, and pharmacists.

The curriculum has been designed to include a wide range of subjects, including applied metabolism, nutritional inventory, and the practical aspects of establishing nutritional support services with particular emphasis on the role of hyperalimentation and tube feeding in the care of hospitalized patients. At the completion of the seminar, participants will understand the clinical relevance of new nutritional modalities as well as the practical application of research in metabolism, wound healing, cancer and immunology and will be able to apply them in clinical practice to the patient at risk for nutritional deficiency. Controversial areas and questions from course registrants will be discussed at specified periods.

COURSE APPROVAL:

"As an organization accredited for continuing medical education, the Mount Sinai Medical Center of Greater Miami certifies that this continuing medical education activity meets the criteria for 13½ credit hours in Category I of the Physician's Recognition Award of the American Medical Association," and 13½ mandatory hours for FMA. Approved for 13½ prescribed hours by AAFP.

Continuing education contact hours have been applied for (FNA).

A request has been made to the American Dietetic Association for continuing education credit for dietitians.

Mandatory CME hours by the Florida Board of Pharmacy have been requested.

Federico R. Justiniani, M.D.
Director of Medical Education

FEE—PRACTICING PHYSICIANS $35
$15 FEE FOR NURSES, DIETITIANS AND PHARMACISTS

Please make check payable to Postgraduate Seminar and mail with registration form to:

CME Coordinator
Mount Sinai Medical Center
4300 Alton Road
Miami Beach, Florida 33140

WEDNESDAY, MAY 10, 1978

AFTERNOON SESSION:

Presiding: **Harold M. Unger, M.D.**

12:00 Noon	1:00pm	Registration and Visit Exhibits
1:00pm	1:30pm	Introduction to the Problem of Nutritional Needs and Definition of the Problem ..... **John M. Kinney, M.D.**
1:30pm	2:15pm	The Energy Requirements of the Acutely Ill ..... **John M. Kinney, M.D.**
2:15pm	3:00pm	Energy Balances and Protein Metabolism In The Acutely Ill ..... **Joel B. Freeman, M.D.**
3:00pm	3:30pm	Exhibits and refreshments
3:30pm	4:00pm	General Principles of Total Parenteral Nutrition .... **Joel B. Freeman, M.D.**
4:00pm	4:30pm	Peripheral Amino Acid Solutions vs. D5W as the Major Postoperative Fluid Replacement ..... **Joel B. Freeman, M.D.**
4:30pm		Visit Exhibits

EVENING SESSION:

Presiding: **David J. Russin, M.D.**

7:30pm	9:30pm	"Clinical Strategy in Nutritional Problems" The Panel will apply principles discussed in the Afternoon Session to case presentations related to specific problems: Cancer — Respiratory Failure COPD — Inflammatory Disease of the Bowel Sepsis — Renal Failure Panel: **David J. Russin, M.D., Arnold Blaustein, M.D., Joel B. Freeman, M.D., Stuart Gottlieb, M.D., John M. Kinney, M.D., Kenneth Ratzan, M.D., Marvin A. Sackner, M.D., Ronald Shane, M.D.**

THURSDAY, MAY 11, 1978

SPECIAL MORNING SESSION FOR NURSES, DIETITIANS, AND PHARMACISTS

8:00am	9:00am	Registration and Visit Exhibits
9:00am	11:00am	"Parenteral Nutrition: Indications and Complications" **David J. Russin, M.D. Joel B. Freeman, M.D.**

THURSDAY, MAY 11, 1978

AFTERNOON SESSION:

Presiding: **Lee D. Goldberg, M.D.**

12:00 Noon	1:00pm	Registration and Visit Exhibits
1:00pm	1:45pm	Hormonal Factors in the Regulation of Body Fuel Metabolism ..... **Philip Felig, M.D.**
1:45pm	2:30pm	Obesity: Cause, Consequence, Management ..... **Lee A. Bricker, M.D.**
2:30pm	3:00pm	Exhibits and Refreshments
3:00pm	3:45pm	Fuel Metabolism in Exercise ..... **Philip Felig, M.D.**
3:45pm	4:30pm	"Clinical Problems in the Management of Obesity" Presiding: **Fredrick M. Rosenbloom, M.D.** Panel: **Lee A. Bricker, M.D., Philip Felig, M.D., Lee D. Goldberg, M.D., Irvin H. Willis, M.D.**
4:30pm		Visit Exhibits

EVENING SESSION:

Presiding: **Harold Glick, M.D.**

7:30pm	8:15pm	Changing Concepts in Hyperlipidemias ..... **Lee A. Bricker, M.D.**
8:15pm	9:00pm	Overview of Surgery for Obesity and Hyperlipidemias ..... **Joel B. Freeman, M.D.**
9:00pm	9:30pm	Question and Answer Period Presiding: **Harold Glick, M.D.** Panel: **Lee A. Bricker, M.D., Philip Felig, M.D. Joel B. Freeman, M.D., Leon Manheimer, M.D.**

FRIDAY, MAY 12, 1978

MORNING SESSION:

Presiding: **Seymour L. Alterman, M.D.**

8:15am	9:00am	Visit Exhibits
9:00am	9:45am	Nutrition and Drug Therapy ..... **Daphne A. Roe, M.D.**
9:45am	10:30am	Iron and Trace Metals Metabolism ..... **W. M. Awad, M.D., Ph.D**
10:30am	11:00am	Exhibits and Refreshments
11:00am	12:00 Noon	New Notions About Vitamins ..... **Daphne A. Roe, M.D.**
12:00 Noon		Exhibitors Prize Drawing

CLASSIFIED ADS

Physicians Wanted

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FAMILY PRACTICE — Excellent opportunity for physician to perform general practice in expanding North Florida community. Attractive 128-bed new hospital that provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

FAMILY PRACTICE ASSOCIATE WANTED. Possibility of partnership in future. Contact: Ronald M. Thompson, M.D., 6215 South Dixie Highway, West Palm Beach, Florida 33405. Phone: (305) 582-7451.

GENERAL PRACTITIONER: For well equipped medical clinic immediately adjacent to 120 bed skilled nursing facility; would also act as medical director for nursing home. Salary 100% of intake. Contact: Administrator, Wakulla Manor Nursing Home, P.O. Box 508, Crawfordville, Florida 32327. Phone: (904) 926-7181.

FAMILY PRACTITIONER OR INTERNIST WANTED to share facilities with four practitioners in solo practice. Major equipment provided. Rent $250 per month. Competent laboratory and x-ray with income based on use. Bookkeeping system and receptionist shared. Financial assistance available to right party. Contact: T. C. Kenaston Jr., M.D., Box 550, Cocoa, Florida 32922.

FAMILY PHYSICIAN — to associate with two AAFP physicians on South Florida Gold Coast. Salary and % first year; eventual partnership. Curriculum vitae. P.O. Box 2265, Delray Beach, Florida 33444.

SPECIALISTS

CARDIOLOGIST, FAMILY PRACTITIONER. Immediate openings. Private solo practices, except FP could be partnership. Financial assistance including first year rent free in professional building adjacent to hospital. Contact Claude Weeks, Executive Director, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

SEMI-RETIRED CERTIFIED INTERNIST SEEKING WELL QUALIFIED INTERNIST to share fully equipped office in Palm Beach, Florida. All services furnished. No investment required. Send curriculum vitae to C-842, P.O. Box 2411, Jacksonville, Florida 32203.

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DERMATOLOGIST, FAMILY PRACTITIONER. Immediate openings. First year free rent and equipment loan. Private, solo practices in professional buildings immediately adjacent to hospital. Contact: Claude Weeks, Executive Director, Flagler Hospital, P. O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

MIAMI FLORIDA AREA. Multispecialty group seeking Internist and General Practitioner. Write or call collect, J. E. White, Medical Director, 1025 E. 25th St., Hialeah, Florida 33013. Phone: (305) 696-0842.

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Situations Wanted

30 YEAR OLD FMG WITH FLEX-ECFMG and Florida license, board eligible, general surgery. Presently doing one year of peripheral vascular surgery. Desires solo, partnership or group. Will consider all locations in Florida. Contact: Antonio Vasquez, M.D., 2799 W. Grand Blvd., Detroit, Michigan 48202.

THORACIC CARDIOVASCULAR GENERAL SURGEON, now Clinical Professor of Surgery, wishes to transfer practice to Florida. Association or group desired. Hospital full time also considered. Write C-835, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL AND VASCULAR SURGEON, 35, university trained, board certified, Florida licensed. Seeks practice opportunity, solo, partnership or group. Available 3 months notice. Write C-837, Box 2411, Jacksonville, Florida 32203.

POSITION WANTED: 35 years old, board certified general surgeon, Florida licensed, wishes to relocate in Florida. Group, hospital based or partnership. Contact: Jorge A. Melandez, M.D., F.A.C.S., One Hillside Drive, Batavia, N.Y. 14020. Phone: (716) 343-5563.

GENERAL SURGEON, SUBSPECIALTY SURGICAL ONCOLOGY, ABS, university trained, completes military 10/78, desires group or partnership. Curriculum vitae on request. F. Silverman, M.D., 7 Wooden Shoe Lane, Longwood, Florida 32750.

CARDIOLOGIST, board certified, 35, skilled invasive and noninvasive techniques, Florida licensed, desires relocation. Write C-861, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST, 30, ABIM eligible, seeks groups, partnership or hospital based practice in Florida. Available July 1978. Reply to C-852, P.O. Box 2411, Jacksonville, Florida 32203.

FAMILY PRACTITIONER, board certified, Florida licensed, seeks relocation to Florida. Age 56. Over 31 years private practice. Additionally — academic and some administrative experience. Curriculum vitae on request. Write: Edward H. Davis, M.D., 315 Beach 143 Street, Neponsit, New York 11694.

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Practices Available

GENERAL PRACTICE FOR SALE: Located in fast growing area in Tampa. Fully equipped. Will introduce. Reason for leaving: going into residency training. For further information write to: John A. Johnson, M.D., 13857 Oak Forest Blvd., North, Seminole, Florida 33542. Phone: (813) 393-9367 (nights).

GENERAL SURGERY PRACTICE WITH OFFICE BUILDING for sale for price of building and equipment alone. Practice, consisting of 70% general surgery, 30% vascular surgery, with some general practice grosses over $220,000 yearly. Office building with modern x-ray and lab has several units providing high rental income. Located in Central Florida on west coast. Write C-865, P.O. Box 2411, Jacksonville, Florida 32203.

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Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

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Below 15	Use not recommended

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Final classification of the less-than-effective indications requires further investigation.

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Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

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It is intended to provide an intensive review of those aspects of internal medicine which should be familiar to internists qualified for certification. Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented daily.

Twelve printed texts, selected references and self-assessment examinations will be provided to all registrants. Audio-visual teaching aids will be available throughout the meeting for self instruction and reinforcement. Simultaneous small group conferences in which illustrated aspects of each subspecialty followed by open discussions also will be held.

ACCREDITATION:

Supervised CME Activities: 84 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that this continuing medical education offering meets the criteria for 84 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed.

Self-Instructional Materials: 64 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that when these continuing medical education materials are used as directed, they meet the criteria for 64 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association.

The following subspecialties will be presented:

- **ACID-BASE DISORDERS**
- **CARDIOLOGY**
- **CLINICAL IMMUNOLOGY**
- **CLINICAL PHARMACOLOGY**
- **DERMATOLOGY**
- **ENDOCRINOLOGY and METABOLISM**
- **ENVIRONMENTAL MEDICINE**
- **GASTROENTEROLOGY and HEPATOLOGY**
- **GENETICS**
- **HEMATOLOGY**
- **HYPERTENSION**
- **INFECTIOUS DISEASES**
- **NEUROLOGY**
- **NUCLEAR MEDICINE**
- **ONCOLOGY**
- **PATHOLOGIC ANATOMY**
- **PSYCHIATRY**
- **PULMONARY DISEASES**
- **RADIOLOGY**
- **RENAL DISEASES**
- **RHEUMATOLOGY**
- **TOXICOLOGY**

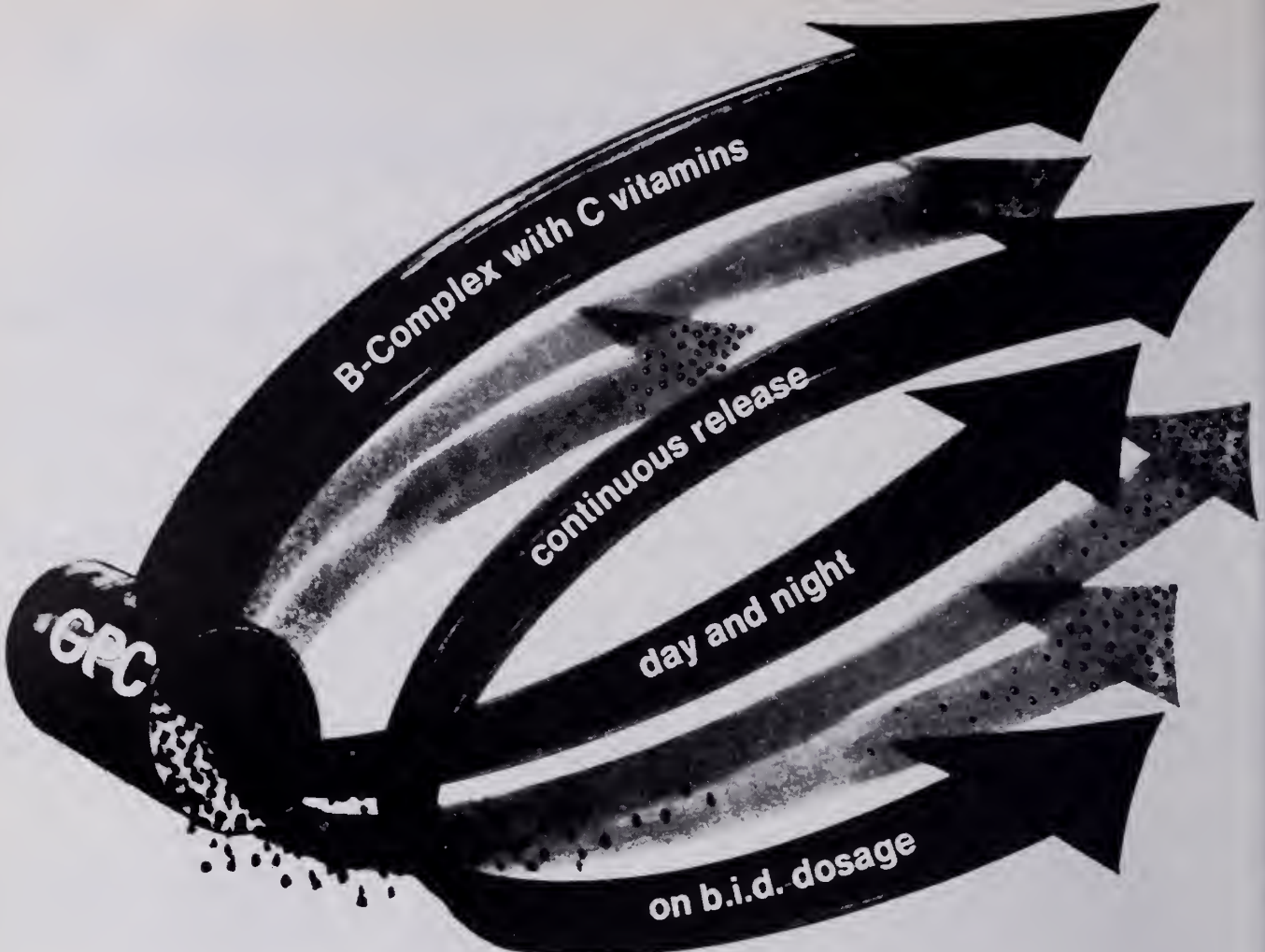
REGISTRATION: $500*

Enrollment must be limited because of extensive faculty/registrant interaction.

For registration and information write to:

J. Bocles, M.D., Department of Internal Medicine
University of Miami School of Medicine
P. O. Box 520875, Miami, Florida
Phone: (305) 547-6063

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Children up to 6 years
Two to three 8 oz. glasses per day.

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Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on:
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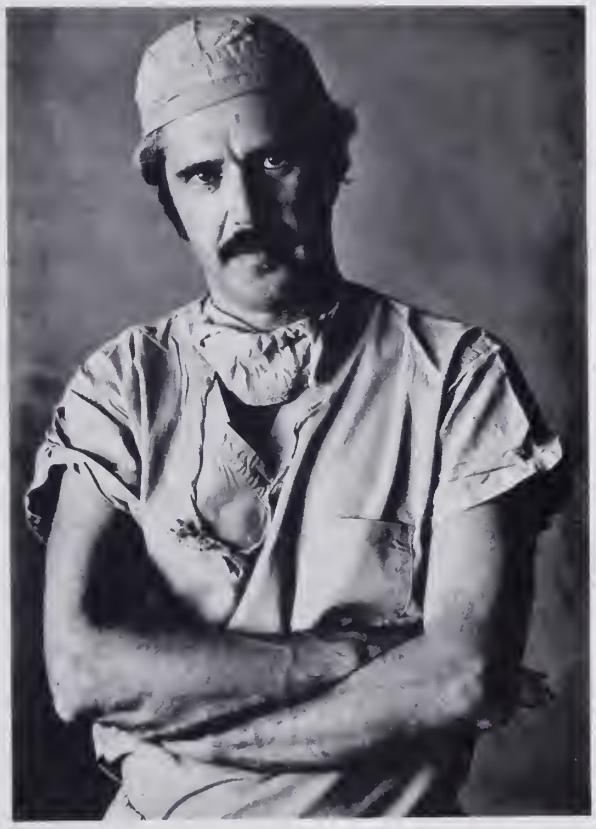
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Your continued ability to practice medicine is your most valuable asset. Practically everything you have, or hope to have, depends on this ability. But what would happen if a serious accident or illness left you totally disabled and unable to earn a living?

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PI-98070-A09

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All FMA members are invited to apply! All FMA members under age 60 may apply for the Income Protection Plan, the plan that provides security against the very real financial threat of disability. For more information, including costs, reductions, exclusions, and terms under which policies may be renewed, just fill in the coupon below. Or, if you wish immediate information, just phone the administrator, PIMCO, (904) 354-5910 or (800) 342-8349. There's no obligation, of course.

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Yes! Please send me additional information about the Florida Medical Association-sponsored Income Protection Insurance Plan. I understand there's no obligation.

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FROM THE EDITOR'S DESK

A welter of misunderstanding and confusion is expected over the Department of HEW's release to the public of 1977 Medicare Program payments to physicians or beneficiaries for medical services or other benefits rendered to Medicare recipients. The figures were to be made available for public inspection about the end of April. The AMA points out that one problem with the list is that it will include a figure totaling payments made to all beneficiaries for each physician's non-assigned claims, but Medicare carriers obviously cannot verify whether the physicians ever received payment from the beneficiary. Also, since these totals are program payments for both assigned and unassigned claims, they will not include deductibles, coinsurance or any reasonable charge reductions mandated by the Medicare Bureau. Finally HEW, in effect, has placed the burden of proving or disproving the accuracy of the listing squarely on the physician without initially providing him with the information necessary for this purpose. **Meanwhile, the Florida Medical Association filed suit in Jacksonville to block release of payment information** **(see page 377).**

Administration leaders have appealed to business and labor leaders assembled in Washington to develop Health Maintenance Organizations (HMOs). About 4 million Americans are now served by HMOs. Since 1971 the Administration has pumped more than $150 million into the program and has asked for $30 million to run the program in fiscal 1979. HEW expects to fund 70 feasibility studies this year, another 70 in 1979. The government expects 172 qualified HMOs by 1982. Meanwhile, under new federal rules, HMOs must make their services available around the clock. Also, they would be required to operate on a fiscally sound basis and have more consumer representation on their governing bodies.

The Joint Commission on Accreditation of Hospitals has published a new edition of its *Accredition Manual for Hospitals*. The standards — including revised rules for emergency services and an expanded statement on patient rights and responsibilities — became effective on publication. Future editions of the manual will be published in August each year, starting this year, and will contain requirements that become effective the following January.

Another national health insurance bill has been dropped into the congressional hopper, this one by Democrat Rep. Paul Simon of Illinois. Simon's bill would cover children up to age six, pregnant women, and families and individuals with high medical expenses because of catastrophic illness. He puts an annual price tag of $29.9 billion on his plan.

University of Oregon medical students will be instructed in their responsibilities in controlling health care costs under a $100,000 grant from Oregon Physicians Service-Blue Shield. The program will cover utilization of medical services, hospital utilization, liability insurance, health insurance, and preventive measures patients can practice themselves. The grant is believed to be the first of its kind since the AMA House of Delegates last year urged medical schools to provide cost-awareness programs for students, house staff and faculty. A related statement signed by the nation's medical school deans urged the corporate community and the public to provide financial support for "new teaching methods and curricular experiments."

The House Commerce Health Subcommittee has voted to exempt individual physician's offices and offices of groups of up to five physicians from national standards for clinical laboratories under the Clinical Laboratory Improvement Act. The bill provides complete exemption for physicians who conduct lab tests themselves for their patients and groups of up to five practitioners if tests are performed only for their patients. Labs in rural areas would receive two-year exemptions.

A House Armed Services Subcommittee has voted down a proposed Defense Department reorganization that would abolish the position of Assistant Secretary for Health Affairs. Subcommittee Chairman Samuel Stratton of New York sharply criticized the planned downgrading of the Department's health division, contending that "any serious degradation in its quality could affect the combat capability of the armed services."

AMA has published a new directory of medical practice opportunities for physicians. An updated *Opportunity Directory* will be published quarterly. This is the first time in the history of the AMA Placement Service that a concise, timely listing of all available U.S. opportunities has been published for physician reference. AMA has also published a new *Physician Directory* containing resumes of physicians seeking locations without use of their names. The publications are available free of charge from the Physician Placement Service, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

Five more jails in six pilot states have been approved for accreditation by the AMA National Advisory Committee to the Program to Improve Medical Care and Health Services in Correctional Institutions. Last year, 16 jails were accredited. The AMA has been working with the medical associations in Georgia, Indiana, Maryland, Michigan, Washington and Wisconsin in the development of jail medical care models under a federal grant.

The AMA is supporting the efforts of the Department of HEW to simplify the regulatory process, open it to more effective citizen participation, and clarify existing regulations through Operation Common Sense. AMA is urging that the project be expanded to include such documents as action transmittals, intermediary letters, program manuals and others, all of which have the effect of formal regulations. One provision of the HEW program to reform regulation development would require the department to seek the advice and opinion of interested groups.

The National Cancer Institute will collect medical records of cancer patients who have used the controversial substance laetrile. Officials hope data from the large number of patients thought to be using the drug will be decisive in determining whether to proceed to clinical trials. Laetrile is now available in 14 states. It has failed to show a reproducible anti-tumor effect in several animal trials.

"Impaired Physician Newsletter" has made its debut in the family of AMA Publications. Published by the AMA Department of Mental Health, the newsletter will be a quarterly and is available free to those requesting it.

AMA and Random House are joining hands to produce books on health care for the public. The series will be called "The AMA Home Health Library." The program will include a wide range of health topics and will be several years in development.

Loose-leaf copies of Volume One of the activities of the AMA-sponsored Commission on the Cost of Medical Care have been mailed to members of the AMA House of Delegates, state and metropolitan county medical societies and specialty groups. The book contains the Commission's summary report, task force reports, comments of individual members and the research agenda.

The Editor

Our new Medical Necessity Program has two worthy goals:

(1) To help contain costs.
(2) To upgrade medical care.

This program initially identifies 28 surgical and diagnostic procedures which will not be paid routinely by Blue Shield. All pertinent claims will be reviewed for medical necessity and covered only when a clear need can be proven.

Following is a list identifying the 28 surgical and diagnostic procedures:

1. Ligation of Internal Mammary Arteries, Unilateral or Bilateral
2. Radical Hemorrhoidectomy, Whitehead Type
3. Omentopexy — Portal Obstruction
4. Kidney Decapsulation, Unilateral and Bilateral
5. Perirenal Insufflation
6. Nephropexy
7. Circumcision, Female
8. Hysterotomy
9. Supracervical Hysterectomy
10. Uterine Suspension
11. Uterine Suspension with Presacral Sympathectomy
12. Hypogastric or Presacral Neurectomy
13. Fascia Lata by Stripper — when used to treat lower back pain
14. Fascia Lata by Incision — when used to treat lower back pain
15. Ligation of Femoral Vein, Unilateral and Bilateral — when used to treat Post Phlebitic Syndrome
16. Excision of Carotid Body Tumor — when used to treat Asthma
17. Sympathectomy, Thoracolumbar, Unilateral or Bilateral — when used to treat Hypertension
18. Sympathectomy, Lumbar — when used to treat Hypertension
19. Basal Metabolic Rate — BMR
20. Protein Bound Iodine — PBI
21. Icterus Index
22. Ballistocardiogram — BCG
23. Phonocardiogram with Interpretation and Report
24. Angiocardiography, using Carbon Dioxide, Supervision and Interpretation Only
25. Angiocardiography, Single Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
26. Angiocardiography, Multi-Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
27. Angiography — Coronary, Unilateral, Selective Injection, Supervision and Interpretation Only, Single View unless in an Emergency
28. Angiography Extremity

This program was developed in cooperation with The American College of Physicians, The American College of Surgeons and The American College of Radiology. We ask your support in making our Medical Necessity Program 100% effective.*

*A claims review by The Florida Plan indicated that most of the procedures were already being screened for medical need and few of the services in question were being performed in Florida.

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NORTH FLORIDA REGIONAL HOSPITAL
and
THE NORTH FLORIDA REGIONAL MEDICAL FOUNDATION
announce
THE FIFTH ANNUAL CARDIOVASCULAR SYMPOSIUM
September 14-15, 1978

The HILTON INN — Gainesville, Florida

Director: Howard W. Ramsey, M.D.
Co-Directors: Luis J. Cintado, M.D.
Thomas D. Bartley, M.D.

This fifth annual symposium is devoted primarily to a review and reappraisal of past and current concepts of diagnosis and treatment of coronary artery disease. A full and exhaustive review of recent data comparing medical and surgical therapy of patients with angina will be presented. Other topics to be discussed include bacterial endocarditis, the myocardiopathies and the current status of cardiac transplants.

A special section of the program, to be presented by Mr. Melvin Belli, will be devoted to an analysis and discussion of current medical-legal problems including the proliferation of malpractice suits.

An outstanding faculty has been assembled for the symposium and the program should be of interest to all physicians involved in the care of patients with cardiovascular problems.

FACULTY

Ralph Alley, M.D.
Christiaan Barnard, M.D.
Melvin Belli, Lawyer
Donald Effler, M.D.
Peter Gazes, M.D.
Goffredo Gensini, M.D.
J. Willis Hurst, M.D.
W. Dudley Johnson, M.D.
Arthur Mauceri, M.D.
Richard O. Russell Jr., M.D.
Earl K. Shirey, M.D.
Douglas R. Shanklin, M.D.
W. Jape Taylor, M.D.

As an organization accredited for continuing medical education, the Medical Education Committee of the Florida Medical Foundation certifies that this continuing medical education activity meets the criteria for 14 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. The medico-legal portion of the program is acceptable for 3 credit hours in Category 2. Approval for 18 hours Prescribed CE credit has been requested from the Florida Academy of Family Physicians, the Florida Board of Pharmacy and the American Society of Radiologic Technologists.

HOTEL RESERVATIONS: A block of rooms has been reserved at the Hilton Inn for symposium participants and reservations can be made through your local Hilton Inn, the Hilton Reservation Service (toll free number listed in your local telephone directory) or by calling the Gainesville Hilton Inn directly (904) 377-4000.

RESERVATION FEES: $175. - all physicians
50. - paramedical personnel (nurses, technicians, etc.)

MAKE CHECKS PAYABLE TO: FIFTH ANNUAL CARDIOVASCULAR SYMPOSIUM

MAIL TO: Howard W. Ramsey, M.D.
Program Director
North Florida Regional Hospital
P.O. Box 13494
Gainesville, Florida

For further information, call: Dr. Howard Ramsey or Hazel Sessions (A.C. 904) 377-8511, extension 195.

THE AUXILIARY BEEPER

FLORIDA MEDICAL ASSOCIATION AUXILIARY — MAY 1978

Dear Readers,

You will be receiving this issue of *The Beeper* after the convention but it contains no report on the convention. You will get that later. This is a special issue written before convention. It is being reproduced by the FMA and bound into the May issue of the FMA Journal, giving us a circulation of 13,500. Remind your husband to watch for it in his office.

Most of the material consists of articles centering around the auxiliary theme of the year, "Reach Out and Touch". They show how the medical community *is* reaching out or how it *can* and *should* do so. There were more individual contributors for this issue than any in the previous four years. I want to thank all the contributors for making this special issue possible.

This is a special issue for me also because it is the last issue for which I will serve as your editor. I want to thank all of you for providing me with this opportunity. It has been my privilege and honor to hold this job for four years. Your new editor will be Mrs. Milton Tignor (Jo) of Palm Beach County.

Mrs. L. G. White (Mae), Editor

HOSPICE — A PROGRAM THAT REACHES OUT TO THE DYING

To work with patients who have been labeled "terminally ill" does not sound like pleasant work, but there is a special nurse at Holy Cross Hospital in Ft. Lauderdale who specializes in just that — Mrs. Mary Sharpe. She is an attractive, energetic brunette with a British accent and a bright smile. She is the director of the new, experimental hospice program. She calls her work "palliative" which means "to make less severe" and she feels it is as important as curing. Many physicians, most laymen and even many clergymen find facing death difficult, but it is actually a part of all human life experiences. When a person is going through this experience, he should not be isolated. He needs to be surrounded by his family and friends and to be touched and listened to.

The ultimate goal of Mrs. Sharpe's hospice program at Holy Cross Hospital is to set up a team of professional people which will work with dying patients from many different points of view — the psychological and the spiritual as well as the physical — and help them to live their last days in the most comfortable and pleasant manner possible.



Mrs. Mary Sharpe, R.N., convention speaker

The foremost fear in these patients is the fear of pain. The Brompton's Cocktail, a gin-flavored combination of highly potent drugs can be used to free them of pain without heavy sedation. "We want to reduce pain," says Mrs. Sharpe, "but also keep the patient alert and active." Drugs should be provided before the effect of the previous dose has worn off and before the patient thinks it is necessary. In this way, it is possible to erase both the memory and the fear of pain. In England, hospice programs are widely accepted. There are 31 of them there and they are housed in separate institutions. People do not dread going to them because they are bright, cheerful places. Staff members really care and surround the patients with love, concern and understanding.

Mrs. Sharpe spent time at St. Christopher's in London, probably the best known hospice in the world. There she watched dying patients play bingo, work at crafts, visit with their grandchildren and even play with their pets!

The program at Holy Cross Hospital is in its infancy, having only been in existence since November of '77. When the team is set up, it will include dietitions to see that meals are attractive and contain favorite foods of the patient in acceptable quantities; recreational therapists who will involve the patients in games or crafts; clergymen to do spiritual counseling which is vital, and social workers and psychologists to do the talking and listening with both patient and family which is so important.

Such a program is long overdue.

REACHING OUT OVERSEAS

by Ann Lombard
Vice President, Interplast East



Anna Milagra Santos

One cold night last January, Tan Airlines deposited a shy, frightened little two and a half year old girl named Anna Milagra Santos in Miami. They had transported her from Honduras at no charge. At the airport to greet her were Interplast East officers and a set of loving foster parents, the Douglas McKennas. After a hug and a few loving words, the McKennas whisked Anna away to their home in Ft. Lauderdale where she would stay for the next two and a half months or until she was completely recovered from her upcoming surgery. Anna had been severely burned at two months when a kerosene lamp fell in her crib. One arm and hand were extensively burned as was her chest and face. In the McKenna home, their own three small children awaited the newest little foster child. They had had the experience of having a two year old boy with them last year.

In the meantime, back in Honduras, a young man named Roberto Fazardo, age eight, was getting ready to journey to Miami to have surgery for a birth defect on his hand. His parents walked for two days to bring him to his place of departure. Roberto arrived a week later and fit perfectly into the Angel Perez family.

After three weeks of building the children up, they were sent to Cypress Community Hospital in Pompano Beach where they were warmly received and cared for by the hospital staff at no charge. Loving foster parents stayed all night to keep the children secure and comfortable. Surgery was performed the next day by volunteer surgeons and anesthesiologists and was successful in both cases. A few days later, the children both went back to the foster parents' homes to recover. At this writing, both Anna and Roberto are happy and proud of their new appearances and waiting to go home to their own parents in Honduras.

Interplast, East is grateful to all the people who help us to help these children. Many things are needed to make this program a continuing one: volunteer foster parents, people willing to transport children, R.N.'s to do private duty nursing during the hospital stay, people to do telephoning and public relations work and, of course, MONEY.

P.S. Interplast, East is the recipient of some of the International Health funds of the FMA Auxiliary.

REACHING OUT IN RURAL APPALACHIA

by Kay McGrady, M.D.

In this day of medical sophistication, it is hard to realize tha the medical needs of the people of Appalachia are still so basi

Moving from a sophisticated pediatric practice in Browar County to a one-doctor, and in fact — only doctor, practice i Appalachia which I did in 1970, was quite a change. It wa simple to practice good office diagnostic and therapeuti pediatrics for the pathology was everywhere and the peopl eager for aid. The real test was getting help in the form c specialist-consultation, more sophisticated diagnostic aids an of course, therapy itself. This area had been virtually ur touched. The people had relied on common sense and hom remedies for generations and only "went down the mountain 35 miles to a 75 bed community hospital with an emergenc room, for true emergencies. My first task, therefore, was t educate them in the ways of preventive medicine.

The County Health Department had been providing immun zations and nurse-oriented well-baby care for years but th closest pediatric clinic was 35 miles away. A satellite "Children Clinic" was operating at the rural community hospital 10 mile away but since there was no pediatrician-in-charge, most of th local people preferred to take the 35 mile trek to the large facility.

With the cooperation of the local Health Department and th rural Hospital Administrator, we updated the clinic. From th Developmental Evaluation Unit at Western Carolina University we obtained the services of psychologists, physio-therapists, an nutritionists who now attend the monthly clinic to do psych logical testing and therapy, provide physio-therapy for the man cerebral palsy patients and provide education on nutrition. attend the clinic and do both sick and well-baby care.

Working with both the State and Federal governments, w were able to implement the WIC (Women, Infants, Children nutritional program in our area. This is a unique program in tha eligibility for it consists of having a *nutritional* need only. Thus it applies to pregnant women, nursing mothers, anemic mother premature infants, sick infants requiring special diets an children with iron-deficiencies as well as a host of othe nutritional abnormalities. There is no income criteria to be met Participants receive a food voucher each month permitting then to buy specific foods and beverages necessary for thei particular need. This really helped in my clinic where th incidence of iron-deficiency anemia was overwhelming.

I spent a lot of time during my first year here working u "look-alike" children with unusual facies. Many turned out to b due to genetic defects, although a large percentage wer attributable to in-breeding. I have since been able to enlist th aid of the Genetics Div. of the Dept. of Pediatrics at both th Univ. of N.C. and Bowman-Gray School of Med. in setting u out-reach clinics here to screen for genetic and metaboli defects and offer counseling.

Relatively few people here have adequate hospitalizatio insurance which complicates the task of treating orthopedi deformities in children. However, the Crippled Children' Commission of N.C. really serves a need here. Regional clinic are held monthly in various outlying areas where, in addition t orthopedic defects, other chronic disabling conditions of child hood are cared for. These include: cleft palate and harelip problems, hearing problems, chronic kidney disease, and con genital heart disease. There is an income eligibility criteria fo Crippled Children's Clinic, but most of the patients here mee this easily. *(continued on page 6)*



chool volunteer Pat Abely (center) working with Latha Padmanabhan eft) and Carol Civitella (right), Charlotte County

IMMUNIZATION PROJECT

Members of the Charlotte County Medical Society Auxiliary ainted a hopscotch stencil at an elementary school to promote he auxiliary's campaign to persuade parents to have their hildren immunized against measles, polio, diphtheria, whoop- ng cough, tetanus, German measles and mumps. After seeing he picture and the write-up in the local newspaper, the rincipal in another school became interested and asked uxiliary members to paint a stencil at her school also. Two more elementary schools are scheduled to be painted soon.

According to Carol Civitella, president, this is a well received roject and only takes approximately one hour with two people working. They found that brushes and a can of paint was easier o work with than cans of spray paint. By the end of the year, ix auxiliary members will have helped to remind 5,500 children f the need for immunization. You can't beat that!

BEAUTIFUL JEWELRY FROM OLD EYE GLASS LENS BENEFITS AMA-ERF

A phenomenal way to raise money for AMA-ERF was born ne Sunday morning in a church in Alabama when Mrs. George Scofield (Pat), 1976-77 president of the state auxiliary, noticed a necklace on her artist friend, Barbara Lavallet. It was an old eye glass lens with beautiful, detailed art work painted on it. She asked Barbara to paint more for her and took them to her county auxiliary meeting to sell and then to the state convention in Birmingham where 90 of them sold in no time at all! The auxiliary was allowed to keep 40% of the profit. After that, orders began to come in from all over the country and now the demand is so great, 14 artists have been commissioned to work on them. People from all over donate their used and discarded eyeglasses. Each lens is meticulously hand-painted by one of these artists. There are literally hundreds of designs with new ones being created each day. For two and a half years, the showcase was Pat's dining room table but now sales have increased to the point where it is necessary to have a regular place of business. A former private house, Signature House, has become the headquarters. It is a place where artists can show their work and sell on consignment. Thursday has been designated "Auxiliary Day". Optics d'Art range in price from $4.50 to $15.00 apiece. Minimum orders are $25.00. For more information, write: Barbara Lavellet, 3913 Shannon Lane, Birmingham, Al. 35213.

MICROBES AND IMMUNIZATION: A NEW MUSEUM EXHIBIT

by Gloria S. Nunn, President, Duval County

Strange as it may seem, my husband and I recently played hopscotch on an indoor burlap court emblazoned with the names of vaccine-preventable diseases. Together we managed to thoroughly squash "POLIO, TETANUS, DIPHTHERIA, WHOOPING COUGH, and RUBELLA". By way of explanation, the occasion for our gamesome activity was a tour of the new medical exhibit about microbes and immunization. The exhibit, located at the Jacksonville Museum of Arts and Sciences, is a Duval County Medical Auxiliary project in response to the AMA campaign to alert both parents and children of the need for immunizations.

In addition to the novel hopscotch court designed by the AMA, the Jacksonville Museum exhibit features a giant microscope (5-feet tall, imitation), real microscopes focused on bacteria and bread molds, and lighted illustrative panels which provide both general information concerning microbes and a simplified explanation of immunization. The Museum Health Coordinator (Mary Burt, wife of a local urologist) has invented a clever puzzle game which promotes interest and understanding of the immunization process; basically, the object of this cardboard game is to fit and attach antibodies or "combat troops" to specific parts of a microbe thereby preventing infection.

Educational tours of the Medical Exhibit are available to the public and also constitute a portion of the health curriculum for Duval County public elementary school students.

CANCER EDUCATION PROJECT HIGHLIGHTED BY WOMEN'S AUXILIARY TO THE SOUTHERN MEDICAL ASSOCIATION

by Jane Hewit, Past President

The promotion of the Dial Access System for Cancer Education was one of the major accomplishments of the Women's Auxiliary to the Southern Medical Association during my year as president which ended in November, '77.

This program is done in conjunction with the M.D. Anderson Clinic in Houston. A physician, nurse or student may select from a catalogue the number of a tape he wishes to hear, and when he calls a toll-free number, the tape is played, giving the information needed. This system is particularly valuable to physicians not practicing in a large medical center. The auxiliary helps with education and promotion of this project at state meetings where Southern Medical Association has a display and distributes current catalogues.

Southern Medical is comprised of 25,000 members in 16 states and Washington, D.C., with Florida leading in membership. During my year as president, I flew 50,000 miles for the organization.

I appreciate the loyal support of the FMAA members who worked on two annual conventions for me. Serving as president of the Women's Auxiliary to the Southern Medical Association was a most enriching experience and an opportunity for which I am most grateful.

I look forward to seeing you all at the next meeting which will be in Atlanta on November 8-12, 1978.

EAVESDROPPING ON THE COUNTIES

by Carrie Saketkoo



The spotlight is on the South Branch of the Broward County Medical Association Auxiliary for its program on the Total Child held on March 14 at the Rolling Hills Country Club in Davie. They picked a timely topic: "Universal Public Education – Is It a Dream?" It was co-sponsored with the School Board of Broward County. Tickets were available through the schools, and teachers who attended were given inservice credits. Educators, community leaders and parents came together for breakfast at 9:30 a.m. and stayed until 1:00 p.m.

Dr. Hugh Adams, president of Broward Community College, was the keynote speaker. Senator Robert Graham of the Florida State Legislature spoke on "Who Picks Up the Tab for Public Education?" Dollye Woodside, Broward County School Board member, spoke on "What Parents Want/What Schools Can Provide." Audrey C. Cohen, president and founder of the College for Human Services of New York, California and Florida, spoke on "Delivering Education – What Are the Needs of Our Teachers?"

Much of the credit for this program goes to the diligent work of Mrs. Joseph Hopen (Selma), Mrs. David Krant (Betsy) and the Education Committee who worked long hours to put it all together. A fantastic job in community service was done by all of them!

Palm Beach County Medical Auxiliary, South Branch, is also to be commended for their Worry Seminar held in Boca Raton Community Hospital on February 22. They had a morning and afternoon session with lunch for only $3.00. There was a choice of two out of eight topics offered:

"Retired to What?", Louis L. Amato, M.D.
"The Calm Before the Storm – Children Ages 6-12", Richard D. Notes, M.D.
"Marital Bliss – Can it be Achieved?", Justin C. Steurer, Ph.D.
"The Alcoholic in our Community, Deprived or Privileged'", Lawrence I. Marcus, M.D.
"Anxiety and Depression at Any Age", Jess V. Cohn, M.D.
"Guiding the Patter of Little Feet", Helen Billings, Ph.D.
"How to be a Family and Survive", Neta Kolasa, M.S.W. and Ted B. Moorhead, M.Div.
"Woman's Place – How to Cope with the Changes", Dorot Stetson, Ph.D. and Sr. Maria Riley, O.P., Ph.D.

Wow, what a seminar!

The spotlight is on the Central Branch of the Pinellas Coun Medical Society Auxiliary, Inc. and Mrs. Frank Williams (Jacki in particular.

Jackie brought Cardio-Pulmonary Resuscitation (CPR) to t auxiliary and a plan for some of their members to teach CPR a community service to interested persons.

In 1974, they first introduced the program. Six membe became certified instructors and taught CPR to more than 3,0 Pinellas County residents.

Did this satisfy Jackie? NO!! Last spring she becan interested in putting CPR into the public school system with t hope that each child graduating from high school would trained in basic life support. Jackie convinced the School Boa of this worthwhile project and got donations from differe large companies and organizations and her auxiliary to he fund the project. She and five other auxiliary members team with the Red Cross and the Heart Association in September a certified the first group of school teachers in Pinellas Count Last I heard, a total of 55 teachers were certified.

Our hats are off to Jackie and her branch of her auxiliary f their never say die attitude! This just goes to prove that if v try hard enough, we can move mountains!

Notice should be taken about our youngest county auxilia – Clay County – and what they are doing. The Clay Coun Medical Society Auxiliary has a service project for the community called "Commonly Asked Medical Questions." It a column which appears monthly in a local newspaper. T questions are submitted by their members.

Orlando's Fifth Annual Women's Worry Clinic, co-sponsore by Orange County Medical Association Auxiliary and Floric Technical University, was held March 10 from 9:00 a.m. - 2:0 p.m. at the First Presbyterian Church. "Making Things Happer was the subject of the keynote speech by Mr. Arnold Howel Attendance was limited to 400. Each chose three of nir seminars to attend.

The Women's Auxiliary to the Brevard County Medic Society and the Brevard Community College co-sponsored the fifth annual Worry Clinic on Saturday, February 11 from 9:0 a.m. until 2:00 p.m.

The speakers were George and Nena O'Neill, whose fir book, "Open Marriage – A New Lifestyle for Couples" was c the national bestseller list for over 40 weeks and has bee adopted as a textbook in hundreds of American colleges ar graduate schools.

The O'Neills have been married for 32 years and have tw grown sons. Their second book, "Shifting Gears, Findir Security in a Changing World" was also highly successful. Mr O'Neill has recently completed a book entitled, "The Marria Premise".

The O'Neills pointed out that there exists in our society "deep desire for a new fidelity by choice rather than coersion. Their helpful suggestions for successful long term marriages a based on the belief that individuals and couples experienc positive growth and change by realistically dealing with life stresses.

The audience of 300 persons was 50% men! The me enjoyed it and found the message to be different and interes ing. Getting the men out for a meeting like this was a speci goal of the auxiliary. Publicity was good and obviousl successful. Congratulations, Brevard County!

SPOTLIGHT



Mrs. Arnold J. Spanjers (Bennie)

Political history was made in Polk County in November of 1976 when Mrs. Arnold J. Spanjers (Bennie), past state president of the FMAA, was elected to the School Board. She was the first Republican elected to a county constitutional office since reconstruction days. Running as the "children's candidate", Bennie said she would not have won without the help of good friends in both parties.

Since then, Bennie has logged many miles attending education-related meetings, most of them at her own expense. An appointment as the School Board representative for the Eighth Congressional District has taken her to Washington, D.C. twice where, as a member of the National School Boards Federal Relations Network, educational matters are discussed with the Florida Congressional delegation.

Governor Reuben Askew appointed her to the Advisory Council of Region V Offender Rehabilitation, and this appointment plus membership on Youth Services Advisory Council and the Florida School Board Association's legislative team frequently take her to Tallahassee.

"The first year in public office was really a learning experience," Bennie said. "This second year is less confusing and the issues come more quickly into focus. By the time I put four years in, I may just know what I am doing!"

Work with the juvenile and adult criminal justice systems has revealed a correlation between basic skills of reading and writing and the degree of criminal activity. Many adult prisoners are illiterate and the average juvenile in our training schools has spent nine years in the public schools and is functioning on the third grade level. "I am firmly convinced that helping youngsters succeed early in life will cut down on the numbers entering the world of crime," said Bennie.

"School-boarding" can take as much or as little time as one will allow. Bennie spends seven and a half days a week at it and that doesn't allow much time for auxiliary work but she has promised to serve as Convention Chairman in 1979.

REACH OUT – A GOOD LIFE PRECEDES A PEACEFUL DEATH

From talking with dying persons, Dr. Elizabeth Kubler-Ross has outlined five stages a terminally ill person experiences in his anticipation of death:

The first stage is denial. (No, not me; it can't be true.) But sooner or later he enters the second stage, profound anger, a "Why me?" attitude. Dr. Kubler-Ross suggests that we assist this angry patient rather than judge him, that we do not take his anguish as a personal insult, that we encourage him to express his feelings. The third stage is a period of bargaining. Often the patient tries to make a deal with God (or with the doctor). In the fourth period he becomes deeply depressed and begins to lose interest in the outside world; he may not want to see his family; they may feel rejected. But his family must allow him to grieve. If allowed to pass through the first four stages, he should reach the fifth and last stage, acceptance. This is a courageous time when a person has accepted reality. In a genuine stage of acceptance, a patient shows a feeling of equanimity and peace. There is a dignity about him.

Fears are problems – fear of physical pain and suffering. Sometimes this fear is justified, but more often it is not. Reassurance comes to the dying if it is clearly demonstrated that nurses and doctors have every intention of controlling discomfort.

Another fear is that of loneliness – the feeling on the part of the patient that he is alone on the brink of an abyss with no one to understand him. Sometimes the patient is more concerned about his family than he is about himself. He feels guilty about leaving them. The dying person needs to receive permission from every important person he will leave behind him. Then he can begin working on his next problem: letting go of all he holds dear. Receiving permission and letting go are at the heart of dignified and peaceful dying. This takes the assistance of understanding friends.

In history, in literature, in philosophy, the theme returns again and again: We learn to die by learning to live well.

An exerpt from a summary of a thesis prepared for USF entitled "An Approach to Death" by Ruth Coleman, Recording Secretary, FMAA.

CHILD ABUSE PAMPHLET

Sponsored by the West Branch of the Broward County Medical Association Auxiliary in cooperation with Child Advocacy, Inc., a pamphlet was recently published on child abuse which will be distributed to approximately 12,000 people in the county. The pamphlet includes the toll-free number (1-800-342-9152) of the Florida Child Abuse Registry which has trained workers taking reports 24 hours a day.

MEET ME IN ST. LOUIS

Start planning now for the AMA Auxiliary's 55th Annual Convention, to be held June 18-21, 1978 at Stauffer's Riverfront Towers in St. Louis, Mo. Scheduled activities include Auxiliary House of Delegates meetings, sightseeing tours, educational seminars, and social events such as a Mississippi River Dinner Cruise. Activities for youths are also planned, so bring your children along. All auxiliary members are invited to attend. Due to the fact that Florida's membership is up to 4,450 (a 10% increase over last year), the state will be entitled to 14 delegates in addition to the president. Hotel reservation forms will be included on the back cover of the Winter issue of Facets. Let's have a big turnout.

ORGANIZED MEDICINE NEEDS ITS AUXILIARY

by Marion Gilliland
AMAA Southern Regional Vice President

We have two motors on our boat: one of suitable size and power to carry it through most waters under normal conditions, the other, a smaller one with sufficient power to give that extra push in heavy seas, gentle enough to push us through the shallows and with enough clout to bring us home if the main motor falters. That auxiliary motor is a source of considerable comfort and security. It is an important part of the boat.

Likewise, auxiliary is an important part of organized medicine. Dr. James H. Sammons, executive vice president of the AMA said not long ago, "Organized medicine NEEDS its auxiliary at ALL levels." That has proven to be true. The auxiliary has helped to pull organized medicine through rough seas and shallow waters. We have even helped to steer them through storms and we will continue to do these things.

But we can do more. Throughout the country, we are operating on approximately half our potential strength of numbers and but a fraction of our potential strength of effort.

Auxiliary membership is just about half that of the AMA. We have much work to do to recruit the spouses of the other half. And we need the spouses of physicians in training and those just starting out in their careers. They are the medical support team of the future.

To be really effective as support for organized medicine, the auxiliary and the medical society must work together at all levels. In many instances this is being accomplished through auxiliary representation on medical association committees and councils, and sometimes on the governing boards of the associations.

On the national level, the auxiliary is represented on two of the 12 AMA councils — the Council on Legislation and the Council of Scientific Affairs. An auxiliary representative is also present at the meetings of the Board of Trustees. In many states, the auxiliary is also represented on Medical Association councils and committees. Our own state president attends one session of the FMA Board of Governors.

The auxiliary is a prime mover in accomplishing some of the goals of organized medicine. Witness the recent immunization campaign throughout the country. We did much to raise both awareness levels and levels of immunization everywhere. And we reaped good public relations along the way.

Legislation is another good example of the effectiveness of auxiliary efforts. Many times the letters we write and the personal contacts we make with our representatives in the legislative bodies of both state and nation have helped to preserve the free practice of medicine.

We are all busy people. Physicians are busy with professional affairs and public service. Their spouses are busy with careers, families and community service. It is a rare spouse who does no community service, but it is a sad fact that many significant efforts are expended doing community service for which some other organization reaps the good public relations. Often they are services also performed by the auxiliary. When they are done in the name of the auxiliary, organized medicine benefits from the positive public relations, and organized medicine needs good, positive public relations almost worse than it needs anything else. It certainly gets brickbats from the press and the public. Individual doctors are all "good guys". It is organized medicine which is the monster in the eyes of the public.

It behooves us to do all we can in the support of organized medicine, to help build its positive image, to keep it free. After all, this is the source of our livelihood and our way of life. It is the system we believe in. It is important to keep it that way.

REACHING OUT IN RURAL APPALACHIA

(continued)

There is such a plethora of pathology and need here in Appalachia and such a paucity of medical personnel. Even here, though, the medical community is reaching out in an attempt to provide good medical care in the midst of poor socio-economic conditions and widespread geographical separation of adequate facilities for diagnosis and care.

FLORIDA MEDICAL ASSOCIATION
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I Want To

love you without clutching

appreciate you without judging

join you without invading

invite you without demanding

leave you without guilt

criticize you without blaming

help you without insulting you

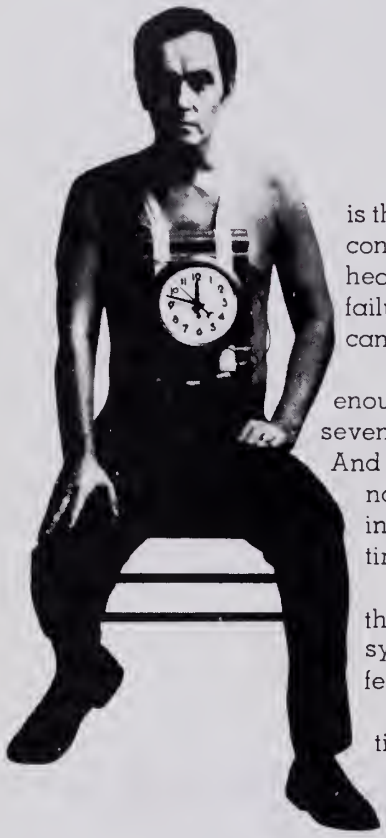
and if I can have the same from you

then we can truly meet and enrich each other

—Anonymous

Submitted to The Journal by Bonnie Cooper, wife of Gary R. Cooper, M.D., Gainesville

ONE-SEVENTH OF YOUR EMPLOYEES MAY BE DYING. HELP SAVE THEIR LIVES.



High Blood Pressure is the country's leading contributor to stroke, heart disease and kidney failure. Any of which can kill.

And, frighteningly enough, one out of every seven of your workers has it. And half of them have no idea they're walking around with this time bomb inside them.

That's because there are usually no symptoms. The victim feels fine.

But all the while, the time bomb is ticking away.

Until, suddenly, it explodes.

But you can help. By giving your employees a chance to check their blood pressure. It takes only seconds to measure a person's blood pressure. And it's painless. Best of all, your own medical or nursing personnel can do the job, simply.

When a case of High Blood Pressure is detected, the employee is then referred to a doctor for treatment. And treatment is usually as simple as taking a pill every day.

To help you implement this life-saving program, we have a special kit, "Guidelines for High Blood Pressure Control Programs in Business and Industry." The kit includes complete instructions on screening, publicity, referral, follow-up, education. And more.



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The Menopause and Its Treatment

Morris Notelovitz, M.D. (RAND) Ph.D., M.B.B.CH., M.R.C.O.G.

The menopause refers to the spontaneous cessation of menstruation secondary to the physiologic aging of the ovary and its decrease in hormone production. The menopause represents one facet of the climacterium — this is a period of transition from the reproductive to the nonreproductive stage of life, and usually precedes the more obvious and dramatic event of the menopause by several years. This distinction is of importance since some of the changes to be described may occur in women who are still menstruating and which are directly related to failing ovarian hormone production. To this group must be added an increasing number of young women who have been surgically castrated, primarily because of severe pelvic inflammatory disease.

Age of Onset

The age at which the menopause is reached is variable but in Western societies it usually occurs at about 50 years of age. Menopause occurring before the age of 40 is said to be "premature" and occurs in about 8% of women.[1]

The Aging Ovary

Aging of the reproductive function of the ovary begins early in life. After the age of 50 follicular activity is rarely seen but the stroma of the ovary remains functional and is capable of synthesizing androgens (androstenedione and testosterone) and, to a minor extent, estrogen. The ovarian stroma is responsible for the production of one third of all androstenedione production — the latter is converted in peripheral tissues (skin and fat) to estrogen. Variation in the degree of this conversion may account for the wide differences in response to the menopause seen among women (see later).

Dr. Notelovitz is Director of the Menopause Clinic, Department of Obstetrics and Gynecology, University of Florida College of Medicine, Gainesville.

The Estrogen Deficiency Syndrome

Deprivation of estrogen — in women previously exposed to normal estrogen levels — results in various symptoms and signs which together comprise the so-called menopausal or estrogen deficency syndrome.

The symptomatology can be divided into two categories: (a) Those presenting during the climacteric and immediate menopausal period — included are vasomotor symptoms associated with autonomic nervous system imbalance (hot flashes, perspiration and palpitations), psychogenic or emotional problems (insomnia, depression, irritability, mood changes and sexual problems) and features related to certain tissue changes (senile vaginitis and urinary problems). It is important to define and recognize these estrogen-dependent conditions since a myriad of other symptoms have been incorrectly attributed to the menopause in the past and have resulted in the indiscriminate use of exogenous estrogen replacement (ERT). The above conditions respond positively to ERT and most necessitate short-term therapy, i.e., courses lasting from six months to two years. (b) Of potentially far greater importance are the "silent" metabolic effects of estrogen deprivation, the results of which manifest many years later with spontaneous fractures (due to osteoporosis) and cardiovascular complications (CHD) such as myocardial infarction. Although other therapy has been advocated[2] long term-estrogen replacement therapy, provided it is commenced within three years of the menopause (and before osteoporosis has developed), will retard bone resorption and prevent the subsequent liability to pathological fractures.[3] The position with regard to ERT and atherosclerosis is less clear; recent work has, however, shown that an increased ratio of high density/low density lipoprotein (as found in premenopausal women) has a protective effect in the pathogenesis of atherosclerosis[4] and is supportive of those who believe that ERT, provided it is started before

intimal damage has occurred, will maintain a normal lipid profile and so provide one factor for effective prophylaxis against CHD.[5]

Diagnosis of Menopausal Syndrome

Estrogen deprivation symptoms can occur before periods cease; in one report 20% of women attending a menopause clinic were still menstruating.[6] The characteristic symptoms in this group related to insidious mood change, loss of libido and a dry vagina during intercourse. They invariably responded to ERT and most occurred in the absence of vasomotor symptoms.

Hot flashes and night sweats are the most frequent and characteristic symptoms of the menopause. Patients complain of a sensation of warmth starting from the chest and progressing to the head and neck. This is accompanied by an increasing redness in these areas and perspiration. In some instances, palpitation or episodes of paroxysmal tachycardia follow. The intensity and frequency of these hot flashes vary considerably. The cause for this vasomotor response is not known but it responds dramatically to ERT. The psychogenic-related symptoms are more difficult to relate to estrogen deprivation. The diagnosis is especially difficult in perimenopausal women and those who have had a hysterectomy.

It is pertinent to note that only about 25-30% of women will seek medical attention — the remainder either tolerate their discomfort without complaint or do not experience them. The latter may be due to the known extra-ovarian conversion of adrenal and ovarian androstenedione to amounts of estrone sufficient to maintain vasomotor and emotional equilibrium. Campbell[7] has shown that plasma androstenedione levels were significantly higher in "non-flushing" than in "flushing" women of the same chronological age.

Measurement of plasma steroids may be of some value. Despite the known diurnal variation a single sample of plasma-FSH (excess of 50 mlu/ml), estrone (<25 pg/ml) and estradiol (<25 pg/ml) will provide adequate documentation of estrogen deficiency and provide the basis on which to plan and assess future ERT. Elevated LH is less helpful as even the three-fold increase found in the climacteric may not exceed the preovulatory LH peak. Some maintain that the various laboratory tests are unnecessary in clinical practice as an equally effective answer may be obtained by the prescription of low dose estrogens for four weeks.[6]

Who Should Receive ERT?

In the absence of symptoms, it is not possible to predict who would benefit from ERT as there are no biological markers that can predict a woman who, for example, is destined to develop postmenopausal osteoporosis — a condition which only occurs in 25% of all menopausal women. Patients who present with climacteric symptoms and certain target tissue-related conditions (atrophic vaginitis and urethral syndrome) are candidates for ERT as are all young premenopausal, surgically castrated women.

How Long Should Therapy Be Continued?

This varies according to the indication. If the objective is to prevent bone resorption (± CHD) treatment should be continued for at least 10-15 years;[8] vasomotor and psychogenic-related symptoms usually require treatment for periods of up to six months to two years, after which time the patient should be gradually weaned off therapy. Intermittent therapy may also be required to deal with recurrent episodes of urogenital symptoms. The duration of ERT must thus be tailored to an individual's need.

How Much Estrogen Should Be Given?

The lowest effective dose should be given; this will vary with the indication for ERT. If the object is to alleviate hot flushes, the dose should be titrated to the level at which maximum relief is achieved with minimal side-effects. With atrophic vaginitis, suitable markers will be the disappearance of symptoms and parabasal cells from the vaginal smear. There are presently no reliable methods of clinically assessing the minimum effective dose required to suppress bone resorption — maintenance of normal fasting levels of plasma calcium is fairly reliable; increased levels of plasma calcium will be indicative of increased bone resorption and hence inadequate therapy. Maintenance of a "normal" premenopausal lipid profile may be the means of monitoring ERT when used as a prophylaxis against CHD. Further research in this area is needed.

Plasma estrogen levels are advocted as this allows for a more objective assessment of the amount of steroid actually absorbed — plasma estrone and estradiol values of 40-80 pg/ml should be aimed for.[9] Persistence of symptoms in the presence of high plasma estrogen values indicates either excessive binding of the hormone with sex hormone binding globulin (making it biologically inert) or that the condition being treated is not related to an estrogen lack. Conversely, lack of response may be due to inadequate dosage or failure to absorb the steroid.

Overdosage of estrogens can be observed clinically by symptoms such as engorged and tender breasts,

excessive weight gain, leukorrhea (due to increased cervical mucous secretion) and, in women with intact uteri, abnormal uterine bleeding. Reduction of the estrogen dose is the primary approach; additional symptomatic relief may also be achieved by the judicious use of diuretics and/or the addition of a progestogen for the last ten days of the treatment cycle.

Less obvious signs of overdosage, or hyper-responsiveness to ERT, may manifest in asymptomatic elevation of the blood pressure and in alterations of the coagulation, lipid and carbohydrate profiles.

Type of Estrogen Used

Although the clinical and metabolic effect of different types of estrogen are said to vary, it is not yet clear whether this is due to the type of estrogen per se or to the dose and biological potency of the preparation being used.[10]

In the United States, preference has, in the past, been given to the use of the natural estrogens (especially those containing estrone sulphate) while more recently, micronized estradiol and other similar preparations have been successfully used in clinical practice. In Europe, there has been a tendency to use estriol, estriol succinate and estradiol valerate as well as micronized estradiol instead of preparations containing estrone.[9] This is based on the recent reports linking estrone (endogenous and exogenous) and endometrial cancer, evidence which is still unfounded and which may be equally appropriate to the other estrogens.

As a clinical guide, 1.25 mg of Premarin® (estrone sulphate and equillin sulphate) has the equivalent biologic potency of 2 mg of Estrace® (micronized estradiol) and 0.02 mg of ethinyl-estradiol. The amount of ethinyl-estradiol in the birth control pill varies from 0.035 to 0.05 mg. In the absence of biologic monitoring, it is suggested that 0.3 to 0.625 mg of Premarin per day or its equivalent be used, and the dose titrated according to the patient's response.

Method of Administration

Oral preparations are preferred because they allow for easy adjustment of the dosage and withdrawal in the event of an unexpected side-effect. The usual practice is to administer the estrogen in three week cycles, allowing the target organs (endometrium and breast) a week of rest. Many patients complain of an increase in their vasomotor symptoms during this break. An alternative approach is to prescribe ERT on a daily Monday to Friday basis (never on weekends); this is particularly of value in women who have had a hysterectomy.

In view of the potential association between long-term ERT and endometrial cancer, it is now recommended that a progestational agent be routinely incorporated into the last week of estrogen therapy. Suitable preparations are: norethisterone 5 mg; medroxyprogesterone 10 mg; or ethynodiol diacetate 0.5 mg daily during the third week of ERT. In the perimenopausal period, this regime will result in endometrial shedding; the patient will thus need to be sufficiently motivated to accept menstruation as part of the treatment of her menopausal symptoms. The proposed use of the progesterone IUD may overcome this objection as it should result in the continuous release of progesterone, thereby inducing endometrial atrophy without interfering with the peripheral and other beneficial effects of ERT.[11]

Subcutaneous estrogen implants are enthusiastically supported by some:[6] a potential problem of implant therapy is irregular bleeding. This can be avoided or greatly diminished by taking 10 mg of medroxyprogesterone (Provera) or ethynodiol diacetate 0.5 mg daily for the first seven days of each month. This problem is not, of course, encountered in women who have been hysterectomized. Estradiol pellets containing 25-50 mg are usually recommended and have an approximate duration of action of six months. To enhance the effect on libido, a pellet of 100 mg of testosterone is sometimes included.

Care should be exercised when prescribing the local use (intravaginal) of estrogen cream. Thus Riggs et al[12] have shown that significant concentrations of estradiol and estrone can be measured in plasma within hours of the intravaginal application of estrogen containing creams. Levels in excess of 100 pg/ml of estrone and estradiol are achieved and persist for 24 or more hours.

Contraindications to ERT

There are certain absolute contraindications to ERT such as severe liver disease, cerebrovascular disease, previous myocardial infarction, deep venous thrombosis and pulmonary embolism and estrogen-dependent tumors of the breast and uterus. Relative contraindications include estrogen-induced hypertension, cholecystitis and cholelithiasis, pancreatitis, cardiac and nephrogenic edema and allergy to certain estrogen preparations. Although estrogens are sometimes associated with a lowering of glucose tolerance, diabetes per se is not a contraindication to ERT.

There is yet another category of conditions where lower doses and/or the combination of progestogens and androgens are recommended. Included are leiomyomata (fibroid uterus), endometriosis, benign cyst of the breast; overstimulation of the endometrium, migraine and epilepsy.[9]

Risks Versus the Benefits

This must be assessed in each patient. Some of the more important risks include thromboembolic vascular disease, cholecystitis-cholelithiasis and endometrial cancer. There is, as yet, no evidence of an increased liability to thromboembolism in postmenopausal women on ERT.[10] Appropriate pretreatment study and subsequent follow-up observation and testing will reduce the liability of the other two conditions to an absolute minimum. The benefit of ERT is considerable. Troublesome vasomotor symptoms are alleviated, there is feeling of well-being with improvement in both psychic and physical health and, according to some, an improvement in the patient's ability to work.[9] The potential benefit of long-term ERT on osteoporosis and possible atherosclerosis may be responsible for a considerable lowering of the morbidity and mortality of aging women.

Recommended Pretreatment Investigation and Patient Follow-Up

In the absence of absolute contraindications to ERT, it is recommended that every patient chosen for long-term therapy should be thoroughly examined before treatment is commenced. This will include assessment of the patient's blood pressure, weight, a thorough breast and pelvic exam and Pap smear and endometrial biopsy (to exclude uterine disease), and the measurement of the following biochemical parameters: fasting plasma glucose, cholesterol and triglyceride, and serum antithrombin (AT) III. The latter is one of the more important natural enzymes responsible for the maintenance of the normal fluidity of blood. Lowering of the blood levels of AT III (congenital or acquired) is associated with an increased incidence of venous thrombosis. Pregnancy and the use of synthetic estrogens in the birth control pill are both associated with lower AT III levels and an increased tendency toward inappropriate coagulation. This has not been reported to the same extent in postmenopausal women on ERT,[10] but care should be taken to exclude women with low pretreatment AT III values.

Experience has shown that apparently normal women may respond in an idiosyncratic fashion to standard doses of estrogen. It is therefore recommended that patients be seen at three months and nine months after the initiation of therapy and then at annual intervals. Care should be taken to assess all of the parameters mentioned above. Pap smears and endometrial biopsies should be repeated annually.

Conclusion

The menopausal or estrogen-deprivation syndrome does exist. This syndrome requires individual management for there are many signs and symptoms in the perimenopausal period that are not estrogen related. Certain well-defined vasomotor, psychogenic and urogenital symptoms are directly related to estrogen lack and can be specifically treated with ERT. Estrogen — as with any other agent used pharmacologically — has certain well-defined side-effects. The benefit of ERT must, therefore, be balanced against potential side-effects in each case. Use of the lowest effective dose and the careful screening for and monitoring of potential side-effects will reduce harmful side-effects to an absolute minimum. Estrogen replacement therapy should be used selectively in women who can appreciate the importance of regular visits to their physician and the need to report untoward symptoms.

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There are times when silence is the best way to yell at the top of your voice.

Anorexia Nervosa
Current Theory and Clinical Application

Irwin Schussler, D.O. and Martin Lazoritz, M.D.

Abstract: This paper presents a discussion of the application of present psychiatric theory and therapy in relation to a severe case of anorexia nervosa treated at the Inpatient Unit of Psychiatry at Shands Teaching Hospital of the University of Florida College of Medicine, Gainesville. The dynamics presented in this classically anorexic patient represent an indepth evaluation of the prodromal occurrences leading to this severe medical illness.

At the time of admission, this 14-year-old Caucasian female had lost 48% of her body weight, so that critical medical care continued for six weeks to two months to ameliorate her severe cachectic, dehydrated, hypothermic state. Psychiatric input was critical to the care plan to resolve the patient's eating problem. Individual dynamics were investigated and therapy emphasized (1) the patient's difficulty with her burgeoning sexuality and (2) her angry feelings toward her parents as role models, both classic anorexic problems.

The patient is being followed on an outpatient basis. As a rule, a multifocal approach is recommended, utilizing both family and individual therapy for follow-up.

The anorexia syndrome defined in 1689 was referred to as "nervous consumption" or "a skeleton wrapped up in skin."[1] In 1874 William Gull[2] coined the term "anorexia nervosa" describing a typical case which included loss of appetite, amenorrhea, constipation, slowing of respiration and pulse, and absence of somatic pathology. He observed it as being typically a condition of young females. At the present time, most investigators feel that the "anorexic behavior," as described in 1965 by Theander,[3] and not the weight loss per se is the issue. Theander considered the condition a conscious and stubborn determination to emaciate oneself despite the presence of an interest in food.

Anorexia nervosa is characterized by a decrease in food intake to the point of insufficient caloric intake to maintain the body at a static weight. Very often amenorrhea occurs, frequently earlier than could be accounted for by weight loss alone. It is therefore felt that other factors help precipitate the amenorrhea, such as hypothalamic insufficiency and interactions in the hypothalamic pituitary axis.

Anorexia nervosa is among the more serious psychiatric disorders and one of the few that may be fatal. Indeed, there is a mortality rate of 25% for those patients who lose in excess of 40% of their body weight.[3] These patients, not recognizing their perilous cachexia, have a distorted body image. They are generally hyperactive and have a preoccupation with food. Each of these symptoms will be elaborated on in relation to the case presented here.

Medical History of the Patient

The patient, a 14-year-old white female, was admitted to the Shands Teaching Hospital in critical condition on July 13, 1975. She (Ruth) had lost approximately 48% of her body weight, dropping from an average of 39.9 kilograms (88 pounds) to a weight of 21.7 kilograms (48 pounds) on admission. At admission the patient's status was so critical that she required intensive-care hospitalization to ameliorate and compensate for her severe cachectic, dehydrated, and hypothermic state. In addition, the patient suffered from bradycardia and severe nutritional deficiencies. She had lost so much of her available body mass that the superior palpebral fat pads had diminished to the point where she could no longer close her eyes, causing her to sleep with her eyes open. The need for critical care continued for almost six weeks, and it was not until the end of two months that Ruth's negative nitrogen balance was finally corrected. During the course of critical-care hospitalization she developed congestive heart failure, lobar pneumonia, bed sores, and gastric dilitation. In view of the high mortality rate for patients with a weight loss of this nature, the main concern was for getting Ruth through the critical medical stages in order to work more closely with the psychiatric aspects of her illness. Even though the critical medical stages took precedence over any psychotherapeutic issues, the input provided by the Child and Adolescent Psychiatric Service and the Genetics-Endocrine-Metabolism staff was critical to

From the Department of Psychiatry, Shands Teaching Hospital, University of Florida College of Medicine, Gainesville.



This sketch, drawn by Dr. Robert G. Iglesias, a practicing Otorhinolaryngologist in Tampa, portrays his conception of the entity of Anorexia Nervosa.

formulating a care plan to resolve the eating problem. When she was finally first able to take nutrition on her own, a modified behavior program, similar to that suggested by Agras,[4] et al, was initiated. As Agras had shown that larger servings potentiate eating, Ruth was presented with considerably more food than she was able to consume (approximately 4,000 calories). Both the Pediatric and Psychiatric staffs set a specific weight goal, and thereafter no formal interaction was held with her on the matter of food intake. She kept her own weight chart, while the medical and psychiatric staffs provided positive reinforcement for weight gain.

The patient had been well until approximately late February 1975. At that time she decided to go on a weight-losing program in order to correct some of her difficulties in the perception of her self-concept. She felt that she was "smaller than all her friends," and although she looked forward to growing bigger, she enjoyed the feeling of smallness and the protectiveness toward her that this inspired in others. At the same time, she had been attracting the attention of a markedly obese 33-year old neighbor (Mr. H.), who had sought her out on a number of occasions. During these times he would actively approach her, making comments about her developing body, particularly her breasts. He would touch her on the breasts, back, arms, and shoulder. As this occurred more frequently, Ruth became increasingly frightened over the outcome of the situation. This fear was further complicated by the apparent inability of her parents to intercede on her behalf against the behavior of Mr. H. Ruth herself, troubled with the imagery that her body changes evoked, became increasingly anxious with her developing breasts and pubic hair. She found it difficult as an early adolescent to integrate the changes she was undergoing, a difficulty which may have stemmed from her early inability to fully integrate her body image in comparison with others, particularly in the area of feminine identification. She had, prior to development of secondary sexual characteristics, demonstrated a resistance to feminine activities and dress. She spent much of her time in the company of her father engaged in pursuits which would normally be considered masculine, such as athletics. Ruth's difficulty in connection with integrating her femaleness into other aspects of her body concept generalized to the point that her overall size concept was severely altered.

Ruth is the youngest in a family of five children, with five years separating her from her next sibling; she stated she both liked and disliked her role of "baby" of the family. Much of her difficulty appeared to be related to the relationship with her mother. She consistently related that her mother never committed herself positively in regard to her own feelings about femininity. For example, Ruth related that her mother had often told her that she had found her own breasts to be a burden. It seemed that Ruth had felt abandoned by her parents and could not seek their reassurance or guidance in working through difficulties with her newly forming sexuality.

Anorexics in general, as in the case of our patient, have difficulty in making an appropriate sexual adjustment. They often appear outwardly interested in sexual matters but in fact may be unconsciously repulsed by sexual thoughts. Indeed, the marked fear of sexuality in anorexics has led some experts to postulate that the unconscious fear of impregnation as a core dynamic is probably nonexistent; however, anorexics have definite sexual identification difficulties and have been shown to have difficulty in learning about sex.[5] Obviously our patient illustrated the difficulty of anorexics in integrating their sexuality with pubescent changes. The outward body representation can become alien because the sexual ideas that it calls forth are ego-alien as well. Both these factors had been reinforced by the patient's external threat, leading also to significant angry feelings toward her mother.

The eroticism that Mr. H. evoked in her caused both concern and delight. This in turn engendered a great deal of conflictual anxiety and guilt. As she became more frightened over Mr. H.'s advances and her own feelings of delight, she became increasingly drawn to him and concomitantly fearful. As she stated, "I think I didn't want to eat because if I did he would pick on my body." Ruth decided, after hearing from her mother the account in a national women's magazine of a woman's problem with anorexia nervosa, that this would be a good way to solve her own dilemma. Unbeknown to her family, Ruth began to diet to decrease her "sexual attractiveness" in about late February 1975.

As do most anorexics, Ruth started her diet independently without professional advice. Anorexics become secretive and reclusive in matters of food and alimentation, even hiding food so that others dining with them will remain unaware of their abstinence. After meals they will induce vomiting and will also abuse cathartics and enemas to help further their goals of thinness. When they do eat, very often it is with an intense sense of guilt and in a hurried, secretive fashion, with just sufficient food intake to maintain their activity. Often, however, they will go on eating binges for short periods of time, giving false hope to their families that this problem has been resolved.

As she lost weight, Ruth began to feel more comfortable. She remarked, "As my breasts began to get smaller I felt very good and no matter how hungry I was I still felt good." The hunger pangs that Ruth experienced provoked far less anxiety and were far less troublesome than her body had been. At this point she had lost

approximately 6.8 to 8.1 kilograms (15 to 18 pounds) and was becoming increasingly hyperactive. Her family interactions were minimal, and her parents remained unaware that she was dieting. However, as her loss of weight became noticeable, her parents became aware and expressed their concern. She countered by preparing elaborate meals for them and involving herself in cooking and being concerned with calories and nutritional items. This preoccupation carried through to the time of her hospitalization. Even while in the progressive-care unit she would offer food to the staff, particularly candy that had been given to her by her mother. When this food was refused she would become offended. Her behavior in this sense was typical of the classic anorexic.

It is incorrect to think that the anorexic patient loses the desire to eat. Such sufferers have in fact an intense hunger and are greatly preoccupied with food. Their interest in food is manifested, however, by an anxiety that other members of their families eat and that they eat well. This facet of anorexic behavior has been referred to by Theander[3] as "alimentary preoccupation."

Vomiting is seen in an estimated 30% of anorexics, usually associated with the more cachetic and severely ill patient. These victims become emaciated as their illness progresses, but they maintain that they are still in need of further weight reduction, often denying at the same time that they are on a reducing diet. Their apparent lack of insight into their changing appearance has been regarded by many researchers as a manifestation of a basic disturbance which involves both body image and an impairment of perception of bodily needs. It is also generally noted that concomitant with this degree of emaciation and lack of recognition of it, the patients maintain a hyperactive posture, often even increasing their activities to the point of extreme exhaustion. Consequently, those observing this high level of activity would feel that the patients have little or nothing wrong. Their remarkable energy in the cachectic state has been seen to be an impaired ability to experience fatigue. It has also been noted that these patients are unable to explain their need for thinness.

At times these patients appear regressed in terms of maturity and have ambivalent feelings about their need to depend upon significant figures in their lives, particularly their mothers. For example, as Ruth's weight dropped, her inability to deal with angry feelings toward her mother became more obvious. Increasingly, there were battles at home about fasting and the weight loss that ensued.

One could view anorexia nervosa as a preoedipal conflict with a struggle for the establishment of a mother-child unity. The effect related to food may be on a rather primitive level as a result of the satisfactions derived from the early eating experience. Much of the child's conflicting behavior toward food does not originate from a lessened need to eat, but from conflicting emotions toward the mother, which are at a certain point transferred to the food itself. In the anorexic patient, aspects of the relation between the love object and eating habits may be exaggerated. The mother, for instance, may foster this by identifying with food statements such as "If you love me you'll eat," or "I just spent six hours over a hot stove," thus enhancing the childhood fantasy of the power of food in relationship to the family.

Anorexics are set aside from ordinary dieters in that the potential anorexic will insist, despite what is actually the case, that he does not need to eat and that he is not hungry. Unlike the normal dieter, he considers not wanting to eat as desirable and rarely complains. Often sudden, unexpected dieting, as seen in these patients, is not as unexpected as it might seem, and intensive case analysis, such as the one we present, demonstrates the dynamics of a case which shows the situation leading up to the anorexic behavior as making sense in the person's total life course rather than being a sudden incident. In this case there was a degree of success as far as the desexualizing of the patient rather than the usual move toward the diet for increasing attractiveness.

In the course of the illness the patient reaches a point where he undergoes a transition from dieting and the resulting desired weight loss to a fixed, unrealistic, nearly phobic fear of obesity. It is at this point that the patient has lost control in the matter of dieting. Patients often describe this loss of control as the point at which they are no longer able to stop their weight loss. The anorexic reaches a physiologic threshold which inhibits his dietary desire and which may be ascribed to a hypothalamic imbalance. In Ruth's case, her anxiety decreased with her weight loss and concept of desexualization, enabling her to alleviate her fear of the loss of appetite control.

As Ruth's weight began to drop more precipitously, her family took her to a local physician. Faced with this virtually skeletal young woman who seemed to be otherwise well, the physician began a total physiological, endocrinological, and general metabolic work-up. Along with this, a local psychologist was consulted who administered the standard extended psychological battery. The general medical evaluation was within normal limits except for the progressing cachexia along with hyperactivity. The psychological report revealed no unusual psychopathology. The patient was subsequently hospitalized locally and was again evaluated, with no substantial changes from the initial evaluation noted. Shortly after being discharged from the hospital, Ruth was rushed to the emergency room and treated for hypoglycemia, having a blood sugar of 8; apnea, and

general cardiovascular instability, including cardiac irregularities and early vascular collapse. Heroic efforts by the emergency room facilities stabilized her, and she was transferred to the Pediatric Service of Shands Teaching Hospital.

Ruth's personal history, in addition to that which has been noted, is typical of the anorexic. She had a history of isolation from peers and was a rather rigid, hard-working young person who felt a great need to succeed, especially in school. As Ushakov[6] reports, these patients tend to be rigid and dogmatic in their attitudes and have a highly developed sense of responsibility, being high achievers academically. Coexisting with this is the difficulty they have usually in establishing peer relationships and their subsequent isolation.

Hospital Course

We made the patient's necessity for weight gain a separate issue to be dealt with mainly by the pediatricians and tangentially by the psychiatric staff. A modified behavior approach was used, encouraging the patient to maintain her own weight chart and move toward her goal of 45.3 kilograms (100 pounds). Tube feeding was required at first, with a weight gain of up to 27.2 kilgrams (60 pounds) required before tube feedings could be stopped. The patient was also provided with an excess amount of food which she could eat or leave at will. The issues that we began slowly to work on were (1) the patient's fear of her burgeoning sexuality, and (2) her angry feelings toward her parents, both as role models and buffers between herself and Mr. H. In addition, we worked on the patient's general inability to deal with her feelings.

Summary

We have presented a typical case of primary anorexia nervosa, showing the core symptoms of distortion of body image, hyperactivity, voluntary restrictions of food intake, amenorrhea (in this case primary), and food preoccupation. Dynamically, anorexia nervosa generally involves difficulty in dealing with sexuality and feelings of anger or aggression. As a syndrome, it must be distinguished by the core symptoms from depression, phobic syndrome, schizophrenia, and hysteria. Once the diagnosis is established, the patient's individual dynamics are to be investigated and therapy initiated.

Our patient was discharged and is being followed in outpatient psychotherapy. As a rule, a multifocal approach is suggested, utilizing family and individual therapy. As in this case, behavioral techniques may be used as an adjunct to psychodynamic therapy, preferably by someone other than the primary therapist, an arrangement which is felt would interfere less with ongoing psychotherapy.

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A BOOKLET PUBLISHED BY THE AMA describes the anatomy of the eye, functional disorders and eye infections. The booklet is titled "How Are Your Eyes?" A section on corrective lenses is included. Cost of the publication is $1.25 each for 1-99 copies; 90¢ each for 100-499 copies; 85¢ each for 500-999 copies; and 82¢ each for 1,000 or more. Write AMA, P.O. Box 821, Monroe, Wis. 53566.

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SPECIAL ARTICLES

Characteristics of Physicians and Their Families

Casefinding Problems and Techniques

Mrs. William H. Harrison

It was brought to my attention at the October 1975 Confluence of the American Medical Association Auxiliary, Inc., that a problem existed among physicians which heretofore had been concealed and to a large extent ignored by the medical profession and the families of physicians as well. The Mental Health Department of the AMA labeled this problem, "The Impaired Physician." At that time Mr. Emmanuel Steindler's booklet entitled, **The Impaired Physician**, was distributed to the participants.

The booklet and the seminar inspired me to undertake this problem as a state project. I introduced it to all the county presidents of organized counties as a special interest of the incoming president. There was no overt interest displayed. However, there were many discreet inquiries and requests for the booklet.

During my travels throughout the state I could sense an undercurrent of anxiety and concern regarding medical marriages. Frequently marital problems were mentioned. The response to my habitual querie as to the type of state program most members would like to have was not surprising. The answer was always the same—How To Live Happily With A Physician. This program materialized and it was an overwhelming success.

When I was asked to participate in the panel discussion on Casefinding Problems and Techniques at the AMA sponsored workshop for the Impaired Physician, I was forced to vigorously promote my special interest.

It was obvious that the women would not respond to the word, "impairment." This veiled problem had to be made visible through some scientific method. A type of survey seemed to be in order. I chose to title it "Characteristics of Physicians and Their Families."

The plan was to use one large county and one small county as a pilot project. The county presidents were contacted to encourage their members to participate. An enthusiastic response accompanied my first request. The second request met with an emphatic, "No!" I then communicated with another small county where I personally knew of two impaired physicians. The Vice-President responded with a letter which read, "We have no impaired physicians here so we cannot be of assistance." The fourth request engendered another lively response.

A cover letter accompanied each questionnaire. It read:

> With the approval of your president, I am enclosing a questionnaire. Will you please complete it and return it to me at the following address:
> You need not sign the questionnaire. I prefer that each one remains anonymous. From these questionnaires I hope to establish some set of extremes or variances.
> I appreciate your assistance in this project.

Out of 350 questionnaires distributed, I had 169 returned by the cutoff date. At least fifty more have been returned since my presentation but they are not included in this report.

There were 48 questions in the survey. Many of the questions were very personal. However, I feel that on the most part, the questions were answered honestly. Some chose to add categories of their own. Many added comments on the questionnaire and several took time to write personal notes.

The survey showed that 95% of the wives felt neglected. Fifty-three per cent thought that a medical marriage was demanding on the wife. Fifty-seven per cent said that the home life was difficult for children. Sixty-five per cent admitted that some member of the family had received professional counseling.

It is interesting to note what appeared to be contradictions. In spite of the above reports, eighty per cent answered that their marriages were happy and comfortable.

Some sideline comments were amusing. When I asked what does your husband enjoy doing, watching television was given as a option. One wife checked it and added, "This is It!" Another question offered was, "Is your husband egotistical?" Thirty-three per cent said, "Yes." Only seventeen people checked, "I don't know." One wife checked yes and to the side wrote, "Oh, boy!" She obviously had a second thought and added in the margin, "In all truthfulness the M.D.'s **must** have a big ego to be an M.D."

When seventy-five per cent admitted that they would blame themselves if the marriage were not running smoothly, it caused me to ponder the answer. They could have blamed their husbands, the children, another woman, impairment, sought counseling, or all of these.

I asked how the home life of the physician ranked with other professions. I arrived at the same conclusion as did Dr. Charles J. Collins who did a similar survey in 1959. As a result of my questionnaire which went to his wife, he sent me his article which was published in the American Journal of Obstetrics and Gynecology. He wrote: ". . . no other group of wives had to adjust themselves to a profession or business which is so paramount in their husbands' lives as that of the medical profession. There is little doubt that these women marry our profession with us and the two merge so closely that often in their eyes they are inseparable."

Toward the end of the questionnaire, I carefully slipped in a few questions dealing directly with impairment. One question read: If you sought help, you would seek help from:

a. A friend of yours
b. Mutual friend
c. Minister
d. Therapy group
e. Psychiatrist
f. All of these if necessary

Ninety-five per cent said a minister.

To the question, "If your husband will not recognize his problem you would: Twenty per cent said they would speak to his closest peer; twenty-five per cent said, "See a psychiatrist;" twenty-two per cent would see a minister and seventeen per cent would find their own outlet. Only seven per cent would seek a separation or divorce.

Many of the questions required introspection on the part of the wife. When I asked her if she were egotistical she most frequently answered, "I don't know." One wrote, "I don't know" and immediately followed it with, "I almost have to be to survive." One difficult question was, "Do you think most doctor's wives are insecure?" Many would not answer. Of those who did, twenty-five per cent said, "Yes." One added, "That's why they drink and get divorced."

I found it difficult to believe that 17% admitted to being struck by their husbands. This was another question that was frequently left unanswered. There were such comments as, ". . . but he was young."

One often wonders why a person marries a physician. I asked, "Why do you like being married to a physician?" I expected many to say, "All of these." They could have said: 1. Because it is prestigious; 2. You are proud of him; 3. You have a nice home and are free of real monetary problems; 4. He is polished and educated. They chose frequently to write in their own choice, which was, "Because I love him." One wife emphasized this as she took the time to write the following note:

> "I am so interested in your panel, and I hope some helpful attitudes are uncovered by it. I sometimes wonder if many women who marry doctors don't have the vision that they are henceforth going to be the recipients of all the benevolent, solicitous attention they have associated with their own doctor — of course, that is sapped up by patients' demands, and that same doctor comes home to be warmed up, succored, etc. so he can go out and dispense that attention another day. Being a doctor's wife **is** a life of giving, and there are so many doctors I know that I wouldn't want to give all that much to — so it all gets back to really loving a particular **person**, wanting the best for him, and enjoying each other's company enough to make it worthwhile—"

The last question I asked was if they had it to do over again, would they still marry their husbands. Eighty-three per cent said they would.

To complete this project, case histories were also drawn up. I was able to obtain only one in the limited time I had remaining. This participant wrote: "I was glad to fill out the questionnaire. I'm pleased you have done this—it's way overdue!" In her history she described her husband's symptoms as "foul language, heavy drinking, not coming home nights, patients leaving the office crying, demeaning and belittling of all people — if you don't have a degree in biochemistry how dare you ask a question." Yet she said that she was the last to know that he had a problem while at the same time she admits, ". . . perhaps I chose not to know." She confessed that he was physically abusive. He thought everyone was sick but him. She stated that she tried to protect him and put

on a good show. To date he has not been disciplined or reported to any of his peers. She has filed for a divorce.

As a result of the questionnaire, inquiries and comments stimulated by the questionnaire, I have come to the following conclusions:

1. The number of **recognized** impaired physicians is not large enough to demand individual attention. (Presently there are 17 in my state on probation and 10 under investigation.)
2. Many cases go undetected. (In my county with a physician population of approximately 200, there have been five suicides and two legitimate attempts within the fifteen years we have resided here.)
3. Wives are not educated to look for impairment in their husbands.
4. The questionnaire would seem to point out one or both of these:
   Physicians tend to marry certain types of women.
   Wives of physicians do not know what is normal to expect from their marriages.
5. Wives want to protect their husband's images—private and public.
6. There might be some correlation between the way wives are treated and the way husbands treat their immediate families as suggested by the questionnaire. (Those who expressed outward unhappiness toward their husbands also stated that the husband was usually indifferent toward his family and did not have frequent contact with them.)

I offer the following recommendations:

Develop county programs which are non-punitive for physicians.

Develop state programs which are non-punitive for physicians.

Develop educational programs for both husbands and wives on how to recognize impairment.

Educate the medical profession to understand, recognize, treat and rehabilitate the impaired physician.

I wish to thank Mr. Emmanuel Steindler, of the AMA, Mrs. Diane Nail and Mr. Ed Hagan of the FMA staff, and the county members who enabled me to complete this study.

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Presented at the "Impaired Physician" seminar sponsored by the Department of Mental Health, American Medical Association and Medical Association of Georgia, Atlanta, Georgia, February 4-6, 1977. Mrs. Harrison is the Immediate Past President of the Florida Medical Association Auxiliary, Daytona Beach.

The Builders

I saw them tearing a building down
A gang of men in a dusty town,
With a yo heave ho and a lusty yell
They swung a beam and the sidewall fell.
I asked the foreman if these men were as skilled
As the men he'd hired, if he were to build.
He laughed and said, "Oh no indeed
Common labor is all I need
For these men can wreck in a day or two
What builders had taken years to do."
I asked myself as I went my way
Which kind of role am I to play
Am I the builder who builds with care,
Measuring life by the rule and square,
Or, am I the wrecker who walks the town
Content with the role of tearing down.

—Anonymous

Is the Saccharin Ban Justified?

Arlan L. Rosenbloom, M.D.

Reasonable estimates are that not more than 5 percent of human cancer is due to viruses and less than 5 percent to radiations. Some 90 percent of cancer in man is therefore due to chemicals, but we do not know how much is due to endogenous carcinogens and how much to environmental factors. An expert committee (WHO, 1965) has concluded that at least half of all cancer in man is due to environmental factors. It should therefore be possible to prevent a great deal of human cancer by finding and removing chemical carcinogens from the environment.[1] *— E. Boyland*

The purpose of this paper is to review the background of the saccharin ban[2] and offer views on the clinical value of saccharin in light of the potential risks.

History

Saccharin (2-sulfobenzoic acid imide) was extracted from coal in 1879 and was found to have 350-500 times the sweetening potency of sugar.[2] A board of scientific advisors to the Secretary of Agriculture in 1912 concluded that .3 gm/day was safe but that higher levels could cause disturbances of digestion. Numerous toxicologic studies were carried out between 1920 and 1950 without any significant findings. Nor were there adverse effects during the two World Wars when saccharin was widely used in Europe; however, no adequate epidemiologic studies were conducted.

Presently 6 to 7.6 million pounds of saccharin are used annually in the United States. Most of this (70%) is in foods and beverages. It is also used in prescription and over-the-counter drugs, particularly those for pediatric use and for persons with diabetes. The chemical is also present in cosmetics (particularly lipsticks), dentifrices, mouthwashes, after-shave lotions, moisturizing skin preparations, hair tonics, skin cleansers, bubble baths, colognes, face powders and douches. There is also some limited use in animal feed and animal drugs.

Testing of Saccharin as a Carcinogen

The first study of chronic toxicity in rats in 1951 demonstrated that high doses (5% of the diet) induced thoracic lymphosarcoma. In 1969 FDA pathologists reevaluated the specimens and findings from the earlier study and found, additionally, papillary excrescenses from the papillae and papillocalyceal junctions of the kidney and increased cellularity of the bone marrow. The presence of the renal changes in the absence of data on the urinary bladder indicated a need for another experiment.

The subsequent study in 1959 revealed that lymphosarcomas were common in control animals with no added effect of saccharin. Bladder abnormalities were found but these were thought to be related to the promotion of bladder stones by saccharin.

The FDA requested the National Academy of Sciences/National Research Council to reevaluate the existing data and they advised further long-term studies with special attention to the kidney and urinary bladder. Between 1970 and 1975 additional studies were carried out on rats, mice and hamsters. Two of these studies involved feeding saccharin to male and female rats from weaning, breeding these rats and studying their offspring for life. These offspring were exposed to saccharin from conception until death. Bladder tumors occurred in a small but highly significant percentage of these animals in a study conducted by the FDA, and in half of the male rats but none of the female rats in a study conducted by the Wisconsin Alumni Research Foundation (WARF).

In these studies, the question was again raised whether calculus formation was increased by the high doses of saccharin. Additionally, an impurity (orthotoluene sulphonamide or OTS) might have been responsible for the effects. Because of these questions, the National Academy of Science review of 1974 indicated that the available data had "not established conclusively whether saccharin is or is not carcinogenic when administered orally to test animals."

At this same time the Canadian government was initiating studies using OTS and OTS-free saccharin. Two generations of animals were fed the material following intrauterine exposure. As in the WARF study, only males receiving saccharin without OTS (7 out of 50) developed bladder tumors in the parental generation. Twelve of 50 male and two of 50 female rats in the offspring generation developed bladder tumors. These results have been evaluated by expert pathologists including scientists from FDA and other institutions in the United States, from Great Britain and from other European countries. The findings are unequivocal and have not been challenged.

Relevance of Animal Studies

"Warning. The Canadians have determined that saccharin is dangerous to your rat's health," Representative James Martin (R, NC).[3]

It is understandable that the general public will not appreciate the significance of carcinogenicity studies in test animals. However, there is some value as well as limitation to the application of such studies. The underlying fact is that chemicals cause cancer, and all chemicals causing cancer in humans save one (arsenic) cause cancer in one or another species of animal.[4] Vinyl chloride was identified by animal testing to be carcinogenic before it was found carcinogenic in exposed workers. Thus, unless the benefits of administration of an agent shown to be carcinogenic in animals are overwhelming, it would be prudent to consider use of such an agent unwarranted in man.

The fact of carcinogenicity of an agent tells us nothing about dose and duration of exposure that will result in human cancer. The use of high doses in animals is necessary to demonstrate carcinogenicity. The dose used is not arbitrary but is based on toxicity study. The animal is administered the highest dose that will not shorten the natural life span from causes other than cancer.

Brown[4] has outlined three assumptions necessary to predict human consequences from a dose known to cause cancer in animals. The first is the notion of threshold. Although it would seem logical that there is a dose of carcinogen below which no one would develop cancer, there is no scientific basis for this assumption. The prudent interpretation would be that there is no safe dosage for a potential carcinogen. The second assumption is that there is a similar sensitivity of humans as animals to the carcinogen. The final article of faith is that there is a relation between dose and response which is linear. That is, that the frequency of tumors is going to be directly related to the average daily consumption of the carcinogen.

One would like to bridge the gap between animal and human studies by epidemiologic investigation. Indeed, several epidemiologic studies have been carried out among persons who ingest large amounts of saccharin and they have not revealed any increased incidence of specific tumors. Negative epidemiologic study provides little reassurance. The more dire extrapolations from the rat data would add an additional 1,200 cases of bladder cancer per year in the United States. Since approximately 30,000 cases of bladder cancer occur annually, this increased risk could not be detected by epidemiologic study.[2] The sensitivity of epidemiologic study is such that it can only detect increased risks two or three times the baseline or greater. However, in a case-control study of 480 men and 152 women from three Canadian provinces, an increased risk of bladder cancer has been associated with saccharin use in the males.[5] The increased risk was not of a magnitude that would have been detectable by morbidity or mortality trends.

Is Artificial Sweetening a Medical Necessity?

The idea that people with diabetes cannot ingest sugar without getting into serious trouble is prevalent. Appreciation that there is sugar in the urine in the absence of ingestion of sugar (produced by glycogenolysis and gluconeogenesis) should be the first clue to a more physiologic understanding of the disorder. Similarly, there has been a partly scientific, partly commercial and partly cultist effort to discredit sugar as a food.[6] It is true that ingestion of large amounts of simple sugars exceeding immediate energy requirements will increase glycemia, urinary glucose and urinary volume in persons with diabetes. Additionally, the ingestion of foods high in sugar in the growing youngster might reduce the intake of better quality nutrients. These concerns would seem to argue for a general reduction in the desire for sweetness in the diet rather than substitution with a potential carcinogen.

For the obese individual there is no reason to single out sugar as the principal cause of the obesity. Caloric excess, whether from sugar, starch, fat or even protein, results in obesity.[6]

It must be emphasized that, despite intuitive protestations to the contrary, there are no data to substantiate a positive role for artifical sweeteners in either the management of diabetes or the control of caloric intake in the overweight. There might be a strong argument for a negative effect of such artificial sweetening.[7] So-called "dietetic" and "diabetic" foods substitute other substances for sugar which result in equivalent or even greater caloric content. Thus, persons are induced to consume more calories than they would if the substances were not so labelled.

The Joslin Clinic has been a long-time advocate of strict dietetic principles in the management of diabetes. It is noteworthy that the comprehensive and prestigious book from that clinic, Joslin's Diabetes Mellitus, does not recommend the use of artificial sweetening as a component of diabetes management.[8] The substance is only mentioned in the context of modern concepts of diabetic nutrition to emphasize that persons with diabetes need not consume special foods but should avoid highly concentrated carbohydrates. The authors caution against artificially sweetened foods that may provide more calories than anticipated.

Sources of the Opposition to the Proposed Ban

Why is there so much opposition to the FDA ban? Consumers Report[3] has outlined the public relations errors that were made by the FDA in its announcement and the unfortunate handling of the news. Anticipating a public scare from announcement of the carcinogenicity, FDA couched its warning in soothing terms that made the ban look ridiculous. The FDA did not foresee that the resultant outcry would be about losing saccharin, not about getting cancer.

The public is opposed to the saccharin ban because, in the case of the individual with diabetes, sugar is considered a poison and for the large segment of the population attempting to control caloric intake, saccharin is thought to be a major weapon in the battle against fat. Diabetes patients and the public need reeducation unless data can be found to substantiate these beliefs.

The diet food and drink industry organized as the Calorie Control Council is opposed to the ban. Who would have expected otherwise?

Politicians are opposed to the ban because they cannot resist such a politically safe issue. The sole adversary of their attack is the FDA. The politicians can respond to the pleas of their constituents, the pronouncements of physician organizations and the lobbying of their industrial supporters (the Calorie Control Council). Meanwhile, they can ride the popular wave of indignation against federal regulation and interference with private lives. More to the advantage, no appropriation is needed.

Should the physician be opposed to the ban? Ideally he will draw on this review and other sources to interpret the risks and benefits for his own patients. It is to be hoped that he will also consider the dangers of placing in the political arena a public health issue that requires careful analysis of risk and benefit data.

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The desire to be recognized, to be important, is no superficial thing. It is one of the basic human drives. Men have fought duels or killed other men because of it . . . It has caused clash and progress. It has caused wars. It has caused people to drive ahead to individual achievement. It has built our civilization and economic progress. It is a drive within ourselves — and other people — that we have to work with, adapt ourselves to, or seek to control.

—K. C. Ingram

The World of Transplantation

Edward Pedrero Jr., M.D.

Since antiquity doctors have tried to transplant organs and tissues from one human being to another. In the seventh century B.C., the Indian surgeon Sushruta published a textbook called **Samhita**, in which he described the first recorded techniques of transplant surgery.

The world of transplantation has been explored, exploited and populated by thousands of patients. Organ grafting has moved from a rare curiosity to the center of the medical stage. In regard to transplantation, it has often been remarked that our technological development has outstripped our emotional and cultural maturity.

Transplantation has brought widespread public attention to the archaic and cumbersome laws that control the disposition of all or part of a body after death. An unresolved problem is the conflict between diverse donation laws which arise when a donation instrument is prepared in one state and the donor dies in another.

A great majority of transplant donation statutes are silent on the right of the donee to make examinations necessary to determine acceptability of the gift. It is essential for an adequate evaluation of the donor's condition to prevent the transmission of any disease from donor to recipient.

Doctors' Dilemmas

An impediment to widespread transplantation is the question of when death occurs. Acceptance of a declaration of death based on neurologic criteria would improve the ability of physicians to maintain whole-organ perfusion death. Legal experts argue that to freeze a definition of death into a statute could seriously impede future medical progress.

In the world of transplantation, the ethics of therapeutic innovation (applying new and unknown procedures to sick people) has grown in importance. Transplantation flouts the ancient principles upon which medical and surgical care are based: do no harm, and help the patient help himself. The welfare of a healthy person, heretofore never sacrificed in human medicine, is now jeopardized when tissue is obtained from the healthy donor. The patient's own immune defenses are flouted and battered, if not destroyed. The abrogation of immunologic processes to achieve success of a transplant is a drastic departure from the ethical maxim of "help the patient to help himself."

The most important in ethical guidelines for therapeutic innovation are those that relate to the patient himself. The concept of "informed consent" is rarely applicable in a liberal sense. How can a patient who has little medical knowledge possibly hope to understand all the complicated pros and cons of a transplant or any other new procedure? How can the doctor, who himself does not know all the answers, help the patient to understand? The uncertainty of the doctor and the strangeness of the patient makes "informed consent" an unattainable ideal. No matter what course tissue transplantation takes in the years to come, it must go through a long period of evolution and innovation, exploring new treatments as alternatives to present-day immunosuppression, so that transplantation can follow the ancient maxim of "do no harm."

Immunology

Peter Brian Medawar and others firmly established the immunological basis of transplant rejection reaction. Knowledge that graft reaction is a function of the degree of histocompatability between donor and recipient led to the development of immunologic techniques by which donor-recipient pairs could be matched.

The matching is possible on the basis of possessing major histocompatability antigens (HLA) in common. The HLA are present on all nucleated cells and are readily detected on peripheral blood lymphocytes which are the cells commonly employed in the identification of the HLA antigens. Transplant immunologists are working to improve the techniques of immunosuppression as perfect matches between donor and recipient in grafting are rare. The price of immunosuppression is damage to the normal chemistry of protein synthesis and antibody production.

The major problem with immunosuppression is that the hosts become more susceptible to infection and the development of malignant tumors. Azothioprine, cyclophosphamide and adrenocorticosteroids have been the most commonly used immunosuppressive agents. There are now newer techniques designed to stimulate functional tolerance. Advances in platelet and granulocyte transfusion support therapy and improved

radiotherapy techniques have helped human bone marrow transplantation become an established mode of therapy in certain hematologic disorders.

The ideal future setting for the grafting of organs in man is the achievement of **specific tolerance** so that no immune reaction occurs after the graft is placed even though other defenses are intact. The production of immunoglobulins that act as blocking antibodies to provide **enhancement** so that even though there was an immunologic reaction, the graft is perfected. Failing to produce either tolerance or enhancement one could strive to hasten **adaption** so that the graft, though arousing an earlier immune reaction, quickly became accepted with minimal immunosuppressive treatment. Tolerance, enhancement and adaption carry the keys to the future of transplantation so that the platitude "the graft lived, but the patient died" is no longer here to be kicked around.

Psychiatric Aspects

Most organ transplant patients undergo a series of emotional changes prior to and following surgery. The transplantation of an organ from one person to another to escape imminent death invokes a remarkable series of emotional stresses and perturbations of the human condition. Prominent among the emotional problems is that of "excessive gratitude." Some patients see their bodily deterioration repaired, rectified and returned to normal living and are deeply disturbed by it. They feel it is a debt they can never repay. They may become antagonistic toward the physician or toward the donor.

Some patients come to life with a new kidney and begin to evince new desires, new plans, new aspirations and the spouses lose their dominant role. Transplantation presents "identity crises," some patients think they are a part of someone else and identify with that person or worry about the fate and life of the other person. Kidney transplant patients sometimes have the overriding insecurity of rejection and being thrown again into severe illness or dialysis.

Prominent among the psychiatric aspects of transplantation is the attitude of spouse and family when a person threatened with death, and assumed to be dying is suddenly returned to life. The family had adjusted their emotional life to the anticipated demise. Deep within their subconscious the family had already assigned the transplanted to a place other than the land of the living. They are shocked when the passive patient returns. This is the phenomenon of "premature mourning." Recipients may feel a spiritual attitude toward the new organ and feel resurrected to a new life. Recipients may feel guilt toward the donor and rationalize guilt-shame defenses.

Studies of kidney donors show that mothers are usually the most willing with fathers running second. Siblings are the least willing and more reluctant than the parents to serve as donors.

Physicians must be aware that homotransplants involve significant emotional and psychic changes in the recipient, donor and family.

Religious Aspects

None of America's three great religions is in direct opposition to transplants. Catholic, Jewish and Protestant theologians all maintain that homografts and heterografts are acceptable and designed to serve humanity.

The theologians maintain that man has the divine obligation to realize that he must give up a part of himself to save another. They cite the law of charity which is based on the natural and supernatural unity of mankind and according to which one's neighbor is another self. It is felt that living man, possessed of free will is unfettered in regard to his own right to donate an organ to his fellow man. The theologians declare that when the preservation of life is at stake, no law interferes, including the laws governing the dignity of the body after death.

The Kidney

The kidney, because of its simple blood supply, its function and being a paired organ, has occupied the attention of transplant scientists from the very beginning. A Viennese journal on January 24, 1902 published the first recorded article on the subject of kidney transplantation. It described in detail the transplantation by Dr. Emerlick Ullman of a dog's kidney into the neck of the same animal.

In 1954, kidneys were successfully transplanted between identical twins. In 1959, a kidney was transplanted between nonidentical twins after the use of whole-body irradiation to suppress the immune response.

X-irradiation was found to be too powerful and transplants were carried out with the use of immunosuppressive drugs to modify the immune response. Antisera from animals immunized to human lymphocytes or thymocytes have been tried with some success in kidney transplants.

A study revealed that about 24,000 kidney transplants have been performed in the United States, and about 10,000 recipients now living have functioning grafts. A long-term study of 556 patients in Denver indicated that if a patient lived one year with a donor organ he had an 80 percent chance of surviving 10 years but with a cadaver organ only 20 percent.

There is a continuing study on the efficacy of

injecting gamma globulin from human placentas into kidney transplant patients. The gamma globulin is administered hours before a transplant and then daily for two weeks following the graft. It has been reported that the gamma globulin injections have doubled the basic two year survival rate.

In 1973, the Federal Government became the major provider of end stage renal disease care with Public Law 92-603, amendments to the Social Security Act and permitting Medicare to cover, with state participation, most of the costs of dialysis and transplantation.

The Heart

More than any previous event, cardiac transplantation brought transplantation science to the attention of the widest possible public. In 1960, Drs. Lower and Shumway of Stanford University reported some of their first studies in heart transplantation in dogs.

In 1967, Dr. Christian Barnard in Cape Town performed the first human cardiac transplantation. The publicity was unequaled in two decades of biomedical science, rivaling news devoted to international politics and the exploration of space. Dr. Barnard's work led to a short-lived and self-limited epidemic of heart transplantations in other centers. Exactly one year after the first heart transplant, the 100th heart transplantation was performed. As of August 1976, a total of 314 cardiac transplant operations had been performed worldwide. Sixty-two patients were alive as of April 1977.

Enthusiasm for the cardiac transplant operation began to wane in 1970 for reasons of histocompatibility and realistic perspectives of the long term survivors. The overall one and two year survival rates for many series were 50 and 40% respectively.

A transplant heart is totally denervated. It has no direct nerve connections with the body of the host. Hearts of young persons transplanted changed to senile hearts with severe coronary arteriosclerosis in only one year's residence in a host. When cardiac transplantation can be relied on to provide a better long-term survivorship and when the late coronary artery disease of rejection is overcome, young patients with severe coronary artery disease will be the most important beneficiaries, especially if they are not amenable to other forms of treatment.

After its sudden launch, cardiac transplantation has slowed down, stranded by late rejection and the need for better methods of immunosuppression. To many biologists working in other fields, cardiac transplantation is the misapplication of human knowledge and the misappropriation of public funds. To the transplant scientist, cardiac transplantation is a field of human endeavor richly deserving close scientific attention and enthusiastic further work.

The Transplant Voyage

How far and how fast to venture in the transplant voyage?

The field of transplantation is not static, it is like every other scientific and medical advance, in a state of constant flux. New discoveries in immunobiology, immunogenetics, drug immunosuppression, whole body irradiation and new techniques in tissue typing, tissue preservation, organ banking, antilymphocytic procedures and homografts, heterografts and xenografts will advance the science of transplantation.

The morality controversy in transplantation is not irreconcilable. The supremacy of mind over matter will solve the problem of rejection. There is a faculty in all — from the most brilliant to the most ignorant and obscure — to perceive truth when distinctly presented.

Is aging a form of self-rejection that takes place over the years, attacking the inner lining of the blood vessels — especially those around the heart?

What man must decide is, does transplantation violate the meaning of life by technologically changing man?

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A REALISTIC LOOK AT COSMETIC SURGERY is provided in the new pamphlet "Aesthetic Surgery . . . What it Can and Cannot Do." Described are some of the more common cosmetic surgical procedures and information on who may benefit from such operations. Cost of the publication (OP 208) is 40¢ each for 1-99 copies; 25¢ each for 100-499 copies; 22¢ each for 500-999 copies; and 21¢ each for 1,000 or more. Write AMA, P.O. Box 821, Monroe, Wis. 53566.

Resume of the Florida Psychiatric Society Fall Meeting

Jose J. Llinas, M.D.

"It has taken 31 years to get you all to come to Pensacola," said Phil Phillips during the closing instants of this well attended reunion, "but I hope you have found the experience worthwhile."

There was general assent that this meeting has been one of the best put on by our Society, both in terms of the high caliber of the presentations as well as the pleasant surroundings, the excellent Sheraton, and the marine city itself.

With an overall theme of sexuality and the family, the papers, with an individuality all their own, reflected scholarly the general concern.

Adolescent Sexuality

In the process of introducing Jim Sussex, M.D., Chairman of Psychiatry at Miami, Steve Schilder, M.D., made the point that, besides his many scientific, academic and administrative accomplishments, Jim is also the contributing "author" (so to speak) of four grown daughters.

The importance of this detail, as often occurs in our field, was not long in becoming openly clear. Jim Sussex, parallel to his engagement in a busy professional life, has been conducting a quasi-professional sideline which consists mainly of friendly, one suspects heavily father-oriented, discussions with young people, preponderantly girls, who have been "referred" by his own daughters. His paper was a masterly description of the psychiatrist as a friendly and pragmatic youth advisor.

He made the initial point that though originally a nation of puritanical beliefs, we are now a culture where productivity is encouraged and, in order to do so, satisfaction of most impulses and "conspicuous consumption" have to be taken for granted.

This open policy of "no restraints," as it were, is one of the factors impinging on the modern development in adolescent sexuality, particularly as it applies to girls. The other very important factor is the civil rights movement of the last few years, particularly that part of it which relates to women's liberation.

Girls obviously do not accept today the outmoded "double standard" in sexual behavior. And yet, in attempting to change it, and perhaps due to female sensibility, they have brought to it a curious sense of restraint. They could have carried out their freedom to the extreme of the male sexual code; they could have gone all the way. Instead, they choose to bring to the concept of sexual liberty the idea that sexual partners should mean something to each other, as individuals, as people. "Whereas their male counterparts, as in the previous generation, used to divide girls into good and bad," Dr. Sussex expanded, "so that we could be full of contempt for the bad ones, (whom we not very elegantly describe as sluts, animals, pigs — certainly not people like us), modern girls in general agree that good girls do it — under certain circumstances."

Boys no longer go to the wrong side of the tracks. And girls, in what is no doubt a moral stance, feel it is acceptable to have relations with a boy they know well, they have grown up with, and with whom they have a meaningful relationship.

People of our own older generation may find this very hard to approve, but we need to recognize that there is an element of health in the direction taken by girls nowadays, as well as a clearly human ethical context.

We need to understand this because, as always, youths need to be able to communicate with their elders. They should not have to feel ashamed to discuss their intimate, delicate, but nevertheless legitimate sexual concerns with us. Worries about petting, masturbation, oral sex, should be approached with an open, nonjudgmental attitude.

In exploring adolescent concerns about premarital intercourse with the aim of aiding the teenager make her own decision, in her own best interest, Dr. Sussex has found four simple self-directed questions to be helpful: Will I get pregnant? Will I lose my reputation? Will I feel humiliated? Will I feel guilty? He discussed in detail the implications of this deceptively simple inquiry. Readers interested in this pragmatic, how-to-do-it presentation, should contact him directly.

Other Activities

One word should be said about the delightful dinner dance: SUPERB! Organized and hosted by the Phillips and the Gordons (Dr. Gordon being, of course, our

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The Florida Psychiatric Society Fall Meeting was held October 14-16, 1977 in Pensacola.

president-elect), this event was a very creative inspiration, with a buffet-supper, where people could not only eat and drink at their leisure, but also visit with one another around the room, making new acquaintances, and renewing old ones.

The Healthy Family

When Sam Hibbs, M.D., got his elevated and well-known figure up to the podium to introduce Jerry Lewis, M.D., he, and some other people in the audience, including Phil Phillips, John Adams, Steve Schilder, Ron Catanzaro, and a few others, knew what a treat was in store. The rest of us just marveled as Jerry Lewis developed his cogent presentation. Some speakers are like painters, outlining their discourse upon a one-dimensional canvas. Others are like sculptors, hewing out of the hard rock of data illuminating, three-dimensional figures. Such is Dr. Jerry Lewis. Without a doubt the highlight of our meeting was this hard-hitting presentation of his massive, 8-year follow up of 100 families.

Dr. Lewis, director of education for the Timberlawn Psychiatric Center and Clinical Associate Professor of Psychiatry at Texas Southwestern Medical School, is a tall, conservatively-attired, steely-eyed research psychiatrist, whose low-key approach to the discussion of his important findings was as elegant as it was effective.

A Clinical Vignette

It is late at night, the adolescent girl curls up in the sofa and listens to the fight between the parents. The mother is very depressed, though she has never acknowledged, nor has her husband, that her mother's death was a very upsetting event. The father is nervous and tense, drinking more than he knows is good for him, despite a recent promotion. The eight-year-old daughter is becoming "too serious;" she cries herself to sleep at night and is having more and more difficulty to get to school every morning. The younger daughter, five, is so sure daddy likes her better than he does mother . . . and she feels both "good" and "bad" about such overt paternal preference.

After painting this picture in broad clinical brush strokes, Dr. Lewis asked what is wrong, and more poignantly, who the patient is. Is it the mother? She is certainly and very obviously depressed; an adverse influence upon husband and children. But what about the father? He is not only painfully fighting off obesity, but also a mild elevation of blood pressure. Or is it the older daughter? Compulsive, passive aggressive and phobic elements are evident in her adjustment. How about the younger girl? Are her excessive feelings of guilt about her normative developmental attachment to father and competition with mother harbingers of more troublesome things to come?

There are no individual answers to this complex clinical problem. In an attempt to develop an articulate and comprehensive approach, examination of the family as a system has come about.

Reorganizing the Adolescent Unit

Dr. Lewis' interest in studying families was sparked by the reorganization of an inpatient adolescent unit. In developing a new program, it was helpful to have an idea of the factors involved in success and failure. Although the treatment program was of some importance, the nature of the youngster's problem and his family background was also significant. It became evident that families had a great impact in the positive outcome of the treatment process, and probably in the causation of the psychopathology in the first place.

A careful review of the records showed that when improvement took place in the hospitalized teenager often someone else in the family decompensated. If the disturbed adolescent began to do better, mother might get depressed; father could develop a duodenal ulcer.

"In other words," Dr. Lewis summarized, "there were families who could not get along without an identified patient."

A Systems Approach

Once one accepts the fact that even a fairly good understanding of individual psychiatric problems does not add up to a complete comprehension of what is happening in the family, the next step is to approach this basic human social unit as a system.

One of the best ways to study a system is to present a problem, and see how the system deals with it. When confronted with a family, one could for instance videotape their response to the question, "What is the biggest problem in this family?" Usually, every member of the family will give a distinct answer and the family therapist, rather than being concerned with ultimate solutions, is interested in the process. That is, how and in what ways do family members react to each other in the process of jointly trying to solve the problem?

A Matter of Judgment

The next difficulty was to try to reach some understanding of how normal, healthy families cope with their problems. A sample of volunteer families was selected in the Dallas area on the basis of their apparent competent functioning; interest in the research; white,

upper middle class status and no identifiable psychiatric disturbance in any of the members.

The families were visited at home; work places were also investigated; as were school and health records. Psychological testing and formal psychiatric assessments were carried out. An early finding of the screening process, as perhaps could be expected, was that not all these families were, indeed, healthy. Some did appear to fall within the limits of normal; many did not.

In showing videotapes of all these families to experienced psychiatric observers, there were some of them that immediately "caught the psychiatrist's eye," so to speak. Some were obviously working very well; many were equally openly dysfunctional.

"Health," Dr. Lewis reminded us, "is a value judgment."

Positive Outcome

In this context, a healthy family turns out to present two firm characteristics: The parents are a supportive system, to each other and to the youngsters; and they raise children who learn to live autonomously and ultimately are able to love people other than those who are a part of the family of origin.

These findings widely reflect results of other investigators in family structure and function.

The Healthy Family

What characterizes a well-functioning family in this exploration? Some of the clearer findings are:

(a) Parental Coalition. The relationship between the parents is described as the strongest bond. Power is freely shared in the marriage and both husband and wife are equally capable of leadership; either one could have the final word, depending on circumstances.

(b) Unusual Intimacy. When one asks either of the spouses in a healthy family, "Who have you been closest to in your entire life?" the answer tends to be a clear and unhesitant, "My wife" or "My husband." It is obvious that this degree of close communication cannot be attained if the relationship is not a fairly egalitarian one, with no dominant, parent-like figures vis-a-vis submissive, child-like ones. They may, of course, engage in occasional arguments, fights and quarrels but there is seldom smouldering, unresolved, long-lasting resentment. They work well together; they make "a good team."

(c) Absence of Other Competing Coalitions Within the Family. The natural strength of the husband-wife relationship prevents the pathological development of father-daughter, mother-son, father-boys, mother-girls types of misalliances; likewise, no mother or father-in-law or natural father or mother connections are of serious importance.

(d) No Extramarital Relationships.

(e) Parents Have a Life of Their Own.

(f) Respect for Individuality of Both Parents and Children.

(g) Clear Communication. People in normal families not only love and respect but they regularly acknowledge each other's communication and differentness.

(h) There Is Little Psychological "Invasiveness". Comments such as "Eat your soup, John, you are hungry" or "Shut the window, Mary, you are cold" are seldom heard within the confines of a healthy family. Normal families discourage gross interference with the other human being's internal space.

(i) Open and Honest Expression of Feelings. Healthy families have a certain psychological knack for "letting it all hang out," as the contemporary saying goes. Parents and children feel freer to express themselves without undue anxiety, inhibition or fear. All families have a baseline mood they usually return to whenever things calm down; healthy families have usually a friendly, optimistic general tone to their lives.

(j) Empathy. The capacity to respond to the feelings or predicaments of another is highly developed in normal families. The "I-know-what-it-must-be-like" attitude is extremely helpful to understand, for instance, how children really feel when confronted with everyday or unusual disappointments.

Male-Female Attitudes

Most of the couples involved in the research were in their early forties (since they had to start as families with a young, 15 or 16 year old adolescent).

The peculiar finding, besides the general characteristics previously enumerated, was that parents, as individuals, appeared to be very unique people; psychologically very well put together, apart from the family context. The fathers were often upwardly mobile executives who had made more money than anyone in their family had before. While they might drink socially, they did not use alcohol excessively; neither did they use tobacco or tranquilizers. There was a complete denial of sexual compulsions or problems. The wives appeared equally competent; functioning well, with a minimum of overt neurotic symptoms.

The children, good-looking and quite adept in their differing developmental tasks, seemed open and available; there was a perceptible difference in personality according to birth order rank. First-borns are more disciplined, better students. Younger ones are a bit less organized and tend to openly express their feelings. Of some importance is the fact that in dysfunctional families, these psychological traits are rigidly gender-related (boys are more intellectual, girls are more apt to express their feelings).

Stance Toward Reality

Normal families can also be distinguished from disturbed ones in the way they relate to the external world in which they find themselves. In the first place, they have an affiliative orientation; they anticipate that good may come out of contacts with the stranger and, therefore, are often rewarded with a positive, self-fulfilling prophesy about the behavior of others.

Second, they realize that human causality of behavior is complicated. When they are faced with a problem, a peculiar bit of behavior on the part of one of the children, for instance, they will quickly move in to try to resolve it. Should the initial approach fail, however, they will usually back off; wait for a while; or try alternative ways of solving the problem. Dysfunctional families, on the contrary, tend to be stereotyped in their responses; if they use punishment, as an example, to try to control behavior and it does not work their next step, more likely than not, will be to increase the intensity of the punishment or rejection. They lack the flexibility of more mature families.

Third, healthy families are more responsive to and more accepting of differentness in human beings, both within and outside the family unit. As a result, members of the group "do not look as though they were stamped out of the same press." Some are shy, retiring, even withdrawn; others are more gregarious and active. They are all acceptable.

"Lives of Quiet Desperation"

More numerous, perhaps, than the group of healthy families, according to Dr. Lewis, is the one of those he describes as "competent, but pained" families. They probably suffer a great deal more than their counterparts and, different from them, the husband-wife relationship in the pained families shows evidence of subtle dominance-submission, unresolved power struggles, significant emotional strain. One major difference is that the mothers are overtly unhappy. They tend to be clinically depressed. They are often overweight; they take Valium or other minor tranquilizers for psychic discomfort; and they see the family doctor every month. They are "sour" women, sour and unfulfilled.

If one asks about satisfaction in their lives, they are apt to comment lamely, "Isn't it lucky that the children are doing so well?" They complain about the fact that their husbands do not spend enough time with them; the husbands are, they say, "remote" and "uninterested." Not uncommonly these sad ladies fantasize about having extramarital affairs.

The husbands, on the other hand, are indeed remote and distant from their wives. They do not spend any more time at home than they absolutely have to; their hobbies are in really solitary occupations. When they talk about work, they do not emphasize pleasures in relationships but rather material achievement, dominance or other expressions of aggressive drives.

The poignant and at the same time reassuring finding in these families is that despite the obvious tragic lives of their parents, the children look reasonably healthy. They do well in school; they relate to others; psychological test profiles are within normal limits.

Heal Thyself

Finally, what can we as psychiatrists learn from the study of families, healthy as well as dysfunctional? We should get a sharper concept of what pathology is, beyond the individual; we should also realize what is possible to accomplish in therapy.

Most of us have experience with two basic family groups: our own family of origin, and our current one. Furthermore, psychiatrists tend not to come from overly healthy families; often the future therapist and peacemaker is, as a child, the go-between in a civil war among parents and others. Working with and understanding troubled families, however, might give us a clearer idea of how much openness and sharing; love and mutual respect, can enrich and expand the limits of successful family life.

Last Presentation

A talk on "Factors Enhancing and Inhibiting Sexuality," was given by Dr. Gene Usdin, Clinical Professor of Psychiatry, Louisiana State University, New Orleans. Dr. Usdin often addresses audiences of general practitioners and lay persons and this was the focus of his presentation. It was a comprehensive and interesting catalogue of the many factors which encourage and those which interfere with adult human sexuality. It was well received by the audience of psychiatrists, psychologists, nurses and parents in attendance.

Finale

In summary, the 1977 Fall Meeting of the Florida Psychiatric Society was an unqualified social and educational success. All those who attended are very grateful to Dr. and Mrs. Phil Phillips, the gracious hosts, as well as Dr. Steve Schilder as Chairman of the Program Committee and Ms. Margo Adams, our competent executive secretary.

We'll see you again in Pensacola — in 30 years, more or less.

● Dr. Llinas, 3615 Southwest 13th Street, Gainesville 32608.

Adolescent Sexuality

James N. Sussex, M.D.

After I accepted an invitation to speak to this group on the subject of adolescent sexuality, I considered what to say and decided that I had a choice of presenting a theoretical discussion of sex and adolescence, with the usual emphasis on the nature of adolescence from physiologic and emotional viewpoints, or an editorial on the apparently changing sexual mores at this point in time in our culture, or a discussion of the subject in a way related to the parents of adolescents and the psychiatrist or other physician who deals with adolescents in his day-to-day work.

I can't avoid at least mentioning some of the theoretical aspects of the problem, and I don't want to pass up all opportunity to editorialize a bit as long as I've got the floor, but I'll try to keep what I say mostly in the area of the problems that any psychiatrist, or indeed any other physician, treating adolescents inevitably has to think about. My remarks will pertain to attitudes more than what to do's and how to's. They are in no way intended to be a definitive discussion of the subject and are really intended as much to stimulate thought and discussion as anything else.

Many of the taboos we regard in the Judeo-Christian cultural setting as matters of religious good and evil are really based on practical matters involving family solidarity as a means of providing safety and security for and acculturation of the children — and even more basically, perhaps, of title to them. Pride of fatherhood may indeed originate in pride of possession and ownership — and the demand for female premarital chastity and marital fidelity the logical way to assure this. Some adolescents — most boys, perhaps, but a few girls too — have always risked the wrath of the father and broken the taboos. Probably the kinds of things that adolescents do sexually have changed little over the years, but degrees of indulgence in various aspects of sexual practice have apparently changed considerably. Premarital intercourse, for example, has always occurred among adolescents in our culture, but there seems little doubt that there is more of it now than even a generation ago. Some people maintain that there is no change in the frequency at all — that it has just emerged into open discussion. Perhaps this is true for total amount of indulgence — the total number of individual premarital sex acts — but there is undoubtedly also a significant increase in the number of people who are not virgins at marriage — some increase among boys, a much greater increase among girls.

Why this increase? Some people attribute it to the availability of relatively easy and relatively certain means of avoiding pregnancy. Surely it isn't this simple. As a matter of fact, the number of girls engaging in sexual intercourse who do not use any contraceptive measure whatsoever is great enough to require us to look for other explanations.

I regard this increase as the product of at least two sets of factors, interwoven perhaps but essentially discrete. The first set of factors is represented by our shift from a culture in which work and productivity, and the self-restraint necessary to assure it, were highly regarded to a culture in which production as such requires less and less of the time and commitment of the people, and the laudable way of life is conspicuous consumption. In our culture nowadays, restraining one's impulses is actually discouraged. Instead the pressure is on the individual to act on his impulses — not to wait — since continual impulse satisfaction leads to continual consumption and this leads to prosperity in our technological society. In this context the pleasure principle is no longer incompatible with the reality principle. Hedonism is no longer anti-American. Fun is no longer wicked.

The second set of factors is embodied generally in the civil rights movement — or at least in that portion of the civil rights movement that has fought for equal rights for women, a battle not yet won but with significant victories in various areas. The TV commercial that has said to the women folk of our nation over the last few years, "You've come a long way, baby" — although this comment is made with reference to women having won the dubious privilege of smoking — applies as well to many other aspects of the lives of women in our culture — manner of dress, use of alcohol, choice of occupation, the vote, and, almost surely, sexual behavior as well. Regardless of whether contraception were possible or not, I feel sure we would have seen essentially the same things we are seeing now in the breaking down of the so-called "double standard" of sexual morality.

I might point out in passing that the concept of a single standard doesn't necessarily imply equal freedom

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of sexual behavior for both sexes. It could just as easily imply equal restriction of sexual activity for both sexes. The fact is that the single sexual standard toward which the trend seems pointed is that which the male of our society has always used as a guideline for his sexual behavior, although perhaps with some significant differences. The male has always regarded freedom of sexual activity, even to the point of frank promiscuity, as right and natural, even commendable, proving his prowess as a male and asserting his right to the admiration and envy of other males. The hunt was the name of the game, and he won who could carve the most notches in his gun, speaking in an obvious phallic symbolic sense.

We still raise our sons this way. We still believe that indulging in sexual activity, at least premaritally and maybe a bit extramaritally, is a natural, normal, and not particularly undesirable way for males to be — as long, that is, as they indulge these natural and normal appetites with someone's daughters other than our own.

Almost Single Standard

Two things seem to me to be happening. First, the girls have been saying with increasing insistence that they won't tolerate being discriminated against any longer with respect to the privilege of sexual pleasure. They have not only demanded more freedom of sexual activity but have insisted they not be regarded as bad girls if they exercise this freedom — that they be subjected to social ostracism no more than are their brothers for comparable conduct. The second thing that is happening though, is that the girls are bringing to this era of increased sexual freedom for themselves their tendency to want sexual activity only when some meaningful emotional tie exists between themselves and their partners — not always, to be sure, the desire for marriage or engagement or even for falling in love but at least some feeling of regard and affection for the partner.

This brings in the difference I referred to earlier. The girls, in their shift in sexual behavior, haven't gone all the way to the male end of the double standard because at that end lay essentially physical sex acts with partners who meant little or nothing as people. The girls have gone from the era of sexual imprisonment through a period that might be characterized as a sexual parole almost to complete sexual freedom, but seldom to what males have long engaged in — sexual license. The girls have introduced an element of interpersonal responsibility in premarital sexual relationships that all too frequently has not existed for the male of our culture at an earlier period. His view then was that good girls didn't — only bad girls did. And since they were bad girls, there was no need to regard them as people — but simply as sluts, whores, pigs. The girls themselves are now demonstrating to boys that good girls do do it with the right boy under certain circumstances. And the girls themselves — not we adults — are teaching our sons something of responsibility in sexual relationships. The girls are teaching the boys that sex with a girl he likes and who likes him is better than sex with someone for whom he's been taught to have only contempt.

And boys, perhaps for these very reasons, are beginning to think more like girls in this respect. Boys these days aren't impressed when dear old dad with a smirk tells them he knows boys will be boys but don't ever take advantage of a nice girl of our own social class — go with one of those little sluts from some other cultural group. Our sons no longer go to the other side of the tracks for their adolescent sex. They do it with the daughters of our best friends — obviously the best people in town!

Boys are restricting most of their sex activity more and more to girls they grew up with, know well, like and respect. Sex appears as part of a broader relationship and, however important it may be or how often it occurs, it is seldom the only reason the relationship exists. Even as recently as when most of us here grew up, it was common for boys to date two kinds of girls, one for sex and another for the other things boys did with girls. Today there is little reason for a boy to do this.

So the double standard is disappearing and the almost single standard that is evolving is probably a considerably more ethical one, in terms of the consideration the sexual partners have for each other, than that by which American males have lived in the past. In this sense, I can see the so-called "sexual revolution" as a move in a healthy direction. It frees girls and women from the chains of sexual slavery and it is having a civilizing effect on boys and men.

But, aside from the good that might be in such changes of sexual behavior, it would be idiotic to argue that grave dangers don't exist. Since the girl is still the one most vulnerable to really serious consequences of premarital sexual activity, it is to her situation that I would direct most of the remainder of my remarks.

Physicians Obligated

Let me say here that I recognize fully the degree of difference of opinion that may exist in this room about the desirability of premarital sexual freedom for girls. Let me urge, though, that we accept the reality of such freedom, whether or not we approve of it, and that as physicians who take care of adolescent girls in our practices we see ourselves as obligated to help them avoid undesirable consequences of their actions — or,

when undesirable consequences do occur, as they inevitably must on occasion, to help them recover from them as quickly and with as little residual damage as possible.

At the outset I will say that I think physicians are not generally, as many seem to regard them, the best people to be the sex educators of our adolescents. Neither, in my experience, are many psychiatrists. For this role we are seldom well-trained. But in our favor is the fact that we are generally regarded as wise, objective, and nonjudgmental, and so we are granted an authoritative role regardless of how little of all of these qualities we may actually possess. Since schools, churches, and parents all abdicate responsibility for conveying valid, realistic sex information to our youngsters, we psychiatrists and other physicians are frequently cast in the role of sex educator even when we would prefer not to be. Discussion of the details of sex behavior with adolescent patients then, as they must face these issues in their lives, becomes not only reasonable but essential. To perform this function adequately, we must have a fair idea of the answers to such questions as these: What is normal? What is abnormal or "perverted"? What is dangerous? And under what circumstances is it more or less so?

Most of us, I presume, would regard sexual intercourse in adolescence as natural and normal even though some would argue that it is immoral or even illegal. The fact is that a great deal of adolescent sexual intercourse is occurring and that some adolescents, while doing what comes naturally, aren't so sure that it is natural. Brainwashed by their — usually — well-meaning parents and clergymen, many adolescents are not at all sure they are normal when they have sex thoughts and impulses to say nothing about acting on them. In the first half of adolescence especially, girls can have grave doubts of their normality when they find themselves growing sexually excited or strongly desiring to move from casual touching or "horsing around" with boys to more specifically sexual interplay. I knew one girl of 14 who developed an actual dread of going into situations in which a boy might touch her — even brush her — because of her embarrassment at the sudden dampness in her genital area. Her parents first became concerned about her because of sudden shyness and social withdrawal, then angry at her when they became convinced she was just being contrary, then concerned again as she began having nightmares, started to lose weight, and began having trouble with her school work. This girl wasn't phobic in the usual sense, although she did have a crippling dread of certain situations. She knew exactly why the dread existed but she was ashamed to discuss it with her mother or any other adult until finally the wise physician who was her family's doctor suspected it might be connected with sexual feelings. He opened up the subject when the girl's guard was down because of his obvious sympathy and desire to understand her, then heard her blurt out her fear of embarrassing herself in public. Reassurance of her normality, coupled with the practical suggestion that she shouldn't hesitate to use a sanitary napkin if she felt particularly vulnerable, were sufficient to meet the immediate crisis. He recognized, however, that her concern was probably overdone and suspected the existence of sexual hangups at a deeper level. He offered her the opportunity for further discussion, not on the basis of her need for psychological help as such but because of her need and desire for more information about her own sexual functions and feelings. In performing this service for her, he may have helped her avert any of several consequences that may follow an adolescent's conviction that she is sexually abnormal.

Possible Consequences

What are some of these possible consequences? This girl was already showing one consequence — an anxiety reaction with phobic features leading to increasing social withdrawal and inability to concentrate on her school work. Other girls might have developed compulsive studiousness and intellectualization, or psychosomatic symptoms, or a depressive reaction, or behavioral symptoms such as suicidal gestures or running away from home, over-eating or self-starvation, or sometimes even delusions or other psychotic symptoms. Once in a while a girl doubting her sexual normality will plunge into sexual activity in a desperate attempt to prove she's normal — not out of any real desire for sex as such.

What about masturbation? Most boys, even in this day and age, are somewhat embarrassed to acknowledge their indulgence in such activity but they don't usually feel terribly guilty or abnormal about it. Those who do need strong and direct reassurance. The occasional one who develops obsessions, compulsions, or schizophrenic symptoms obviously needs psychiatric treatment.

Girls too, though, have conflicts about masturbation. Whereas boys have usually become aware of the near universality of this activity and are in a position to pooh-pooh some of the old wives' tales about it, many girls may still never have heard anyone mention the possibility that they might do it. The result is that the masturbating girl often feels that she surely is the only girl in the world who ever did it. She isn't as likely as a boy to wonder about its having a deleterious effect on her mental or physical capacities, but she will wonder if she's sexually normal. She deserves to be told she is. Since masturbation must surely be the world's most effective means of preventing

precocious or dangerous sexual intercourse, perhaps it should actually be encouraged. The frequency of masturbation in a boy or girl who is worried about masturbating is likely to go down when he or she isn't worried about it so much. The worry itself and the tension it produces lead to masturbation as a means of relief, to be followed surely by the vicious circle of guilt, more worry, more tension, and more masturbation. I doubt that encouragement would increase frequency of masturbation at all. Instead I would predict a decrease in frequency and much less likelihood that crippling anxiety and guilt will develop.

How about petting? Such activity has been known by a variety of different terms at various times, but essentially what we're talking about are those activities characterized by the sexologists as "foreplay" because they presumably are precursors to intercourse. In adolescence, however, they frequently constitute the end itself. Again, let's not argue the morality or immorality of such activity. Let's give a nod toward reality and acknowledge that it's here, close around us, all the time. A good many adolescents who have consciously decided not to engage in intercourse pet to orgasm as readily and regularly as people of our generation would once have engaged in a good night kiss. Such behavior is no longer the hallmark of the class tease, nor does the boy who participates expect, or frequently even want, the girl to participate in intercourse.

Petting has always occurred. Nowadays it's just more honest and straightforward and the ground rules better understood and accepted by both parties. Is it normal? Obviously it is not abnormal, but some people do think that using petting to orgasm as a regular substitute for intercourse, instead of foreplay per se, leads to a tendency after marriage to prefer these activities to intercourse. This view has overtones of fixation and conditioning theories and in some cases I'm sure that happens. In most, however, I am just as sure it does not. The Kinsey group reported that women who had achieved orgasm through petting prior to marriage were more likely to achieve orgasm in intercourse after marriage than those women who had not had such experience. Furthermore, it may be that a girl who has known and enjoyed premarital petting to orgasm as a fairly regular part of her sexual behavior is likely to enjoy her married sex life more in general simply because she is a more experienced and versatile sex partner.

More than anything else except masturbation, perhaps, petting to orgasm has prevented indulgence in sexual intercourse when such indulgence would have been dangerous or unacceptable to either participant. Is there any reason to try to talk adolescents out of this practice? Indeed, there may be merit in encouraging it. The argument that such encouragement will lead to increased intercourse may be nonsense. The intercourse such activity leads to would probably occur anyway. The difference is that with an approving attitude on the part of parents and physician, the adolescent girl wouldn't need to feel guilty and wouldn't need to defend herself against those guilt feeling by developing neurotic, psychosomatic, behavioral, or even psychotic symptoms.

One might argue that simply to look the other way is sufficient. I have doubts about that. When an adult looks the other way the adolescent assumes that he, the adult, is either stupid, a hypocrite, or afraid to face the issue. Any of these impressions is unfortunate and adds to the generation gap. Isn't it far more honest, and indeed safer, to take a definite stand on the matter and tell the adolescent we feel her actions are normal and good, not something to be ashamed of and guilty about?

The subject of petting to orgasm leads logically into the matter of oral sex. Although our culture has always had its advocates of such activity, their inclinations were usually acted upon only with the greatest of secrecy and usually with partners other than their spouses, fiances, or "steadies." Perhaps World War II, in its exposure of American young men to a variety of sexual experience with girls of other countries usually obtainable in this country only in a brothel, is responsible for the great increase of such behavior among adolescents. Somehow this group of young Americans apparently felt free enough to come back and teach their wives and girl friends these other forms of sex activity. This, coupled with or perhaps manifested by the more open description of such activity in even the most acceptable of recent novels, suddenly opened the eyes of America's younger generation of both sexes. In my judgment, premarital oral sex is now nearly as common among adolescents as manual petting to orgasm and possibly more common than intercourse since many adolescents use it as a substitute for the potentially more dangerous act. Boys no longer seem to regard cunnilingus as disgusting or unmanly nor are they nearly so likely as even a dozen years ago to regard a girl who will engage in fellatio as a slut. I have no idea what proportion of oral activity goes to orgasm but it does occur and with amazingly little anxiety, probably less than for masturbation.

What about group sex? I have had reported to me what I would regard as an increasing tendency to engage in various sexual acts, to and including intercourse, in the presence of others. This apparent lessening of concern about privacy is perhaps a natural outcome of the combination of increasing freedom of sexual activity and the traditional pattern of double dating. The practice seems to have begun well before the present group of

adolescents came on the scene, and there are those who believe this phenomenon will increase rather than decrease in the future. Once adolescents begin engaging in sexual activity, they seem to have amazingly little reticence about it among their own peer group. They're all doing the same thing. Exchange of partners sometimes occurs but this appears to me to be rare. Even more rare are sex orgies and the multiple groupings referred to by such terms as "gang bang." The latter kind of phenomenon has occurred all through history, I'm sure, and still does, although I'll wager at no greater frequency than in the past. The girl who engages in such pastimes may well be heading for trouble and in need of help. At the very least she deserves a careful psychiatric evaluation.

This brings us to the matter of constancy and fidelity. Adolescent girls have traditionally been characterized as fickle and inconstant. Well, they are, in the sense that they are engaged in comparison shopping. And now, since sexual activity is accepted as being as much the prerogative of a girl as of a boy, at least in a meaningful relationship, it stands to reason that a girl may well have sexual intercourse with more than one boy, perhaps several, before she marries. But I would argue strongly that most of these girls are not promiscuous — that they are, rather, for the most part amazingly faithful, although serially so. In this their serial monogamy isn't a great deal different from that practiced so freely by their parental generation — except that the parental group is far more likely, in my opinion, to be unfaithful during each marriage than the adolescent girl is likely to be during the time she's going steady with a particular boy. Furthermore, and I think this is important, the boy is also more likely than not to be constant and faithful within the steady relationship.

Does age have anything to do with these things? Of course it does. We can hardly meaningfully bracket 13-year-olds and 18-year-olds in the same discussion. Although fewer girls reach marriage with their virginity and although sexual activity is more accepted generally in adolescence, I am not sure that the age of initial sexual intercourse is going down significantly. However, since our girls are reaching puberty earlier than their mothers and grandmothers, and since maternal pressure on girls for early heterosexual social popularity seems to increase year by year, I wouldn't bet that the trend won't be toward earlier intercourse.

Alternative Paths

If young adolescents are going to engage in sexual activity when they are free to do so — and they are free to do so the moment they first walk out the front door unchaperoned — we have at least three alternative paths to follow: (1) We could decide they can't be allowed any freedom at all and deny it to them — in which case all early adolescent unsupervised and unchaperoned activities would, logically, have to be banned; or (2) we could arm them with as much information as we can and provide them a sound basis on which to make what, to them, are reasonable and supportable decisions, and we could make sure that the decisions we leave to them are backed up by every reasonable measure to prevent them from getting into trouble as a result of those decisions; or (3) we could go on as we have in the past trying to scare them into conformity and making them suffer the horrible consequences if they choose to do their own thing. I am out of sympathy with the third approach not only because it's almost always a miserable failure but also because it perpetuates hypocrisy, dishonesty, insincerity, intolerance, prejudice, and bigotry — all in the name of morality — and with the consequence of many ruined young lives. The only cause for joy among the elders when an adolescent gets into trouble in the context of this kind of teaching could only come out of an essentially punitive attitude toward adolescents which says, in effect, "I told you so — it serves you right."

The first alternative may have merit — restricting unsupervised activities for the younger teenaged group — but it is difficult to convince some parents, especially the mothers but frequently with father's concurrence, who see their daughter's whole future resting on whether she is popular at 13 years of age. These are the same parents who are frantic when they find their sub-debutante making out with a neighbor boy at the poolside party and come running to a psychiatrist with fears that she is on her way to sexual deliquency. As a matter of fact, she may well be, and the parents need help in getting their messages straight.

The second alternative is the only one that makes sense to me at this point in time. If we let our 13 and 14-year-olds out alone, unsupervised, we've got to equip them with whatever information they need to make the right decisions and to protect them against the undesirable consequences of any wrong ones they may make. We don't send a daughter out in the car alone without driving lessons. Why should we send her out ignorant about sex and unprotected against a possible accident. It is amazing to me that in this day and age, when contraceptive information and materials are so easily and generally available, that so many girls of even college age seem to have no idea how to protect themselves against unwanted pregnancy. One could argue that such girls are unconsciously seeking pregnancy or are exhibiting a rebellious "I don't care" attitude and certainly this is true in some instances. For the most part, though, I am convinced that the girls just don't know what to get, where to get it or, if they do get it,

how to use it properly. And they are too self-conscious and embarrassed to go to anyone for help. A girl's peers aren't a good source of contraceptive information even if she could risk showing her ignorance by asking them for it. The results of this amazing ignorance are all too often tragic.

You hope a soldier going into combat never has to use a knife to kill an enemy soldier coming at him at close range — and most soldiers don't have to face such a situation. But you prepare all soldiers for such an eventuality. By the same token a girl going into combat zones with boys should be prepared for anything that can happen to her — not that you expect it to happen but just because it might happen. She should know about her impulses and the emotional and physical signs that tell her they are operating. She should know what sex acts of various kinds are like and how they can be of possible advantage or possible danger to her. She should be given all the information she needs to make sound decisions for herself — because they will be decisions for herself made in circumstances in which a mistaken one could be tragic.

I know one girl who had been using what she called the "rhythm method," a schedule she had been given by a girl friend. How she had avoided pregnancy up to that time was a miracle because it was 180° backward. At any rate, that girl, in my judgment, deserved to know the correct information, as nearly as we can know it medically, about "rhythm." I explained it to her — including the risks. She was horrified and wondered how any girl could trust it, even if she had the sequence correctly. I said I didn't know either how any girl could trust it.

Obviously some girls can be provided with reasons that are compellingly on the side of not engaging in intercourse — but not on the basis of scare tactics. Most adolescent girls aren't stupid. Neither are they neurotic. Most of them want to make decisions that will lead toward happiness and self-fulfillment, not toward misery and self-destruction. Most of them are capable of considerable self-restraint and have a very acceptable value system built up inside themselves already. Most really don't want to become pregnant, or compromise their reputations, or make themselves available for exploitation. Most are perfectly capable of coming to decisions that are reasonable for them if they are helped to look at the real issues involved. I have had good success with quite a few girls who were contemplating possible sexual intercourse with boy friends. Not all were virgins, so loss of virginity as such was not an issue with many of them. Yet they considered carefully four questions I suggested they ask themselves.

Four Questions

Here they are. First, I tell the girl, ask yourself if there's any chance you'll get pregnant. If the answer is yes, you'd probably better say, "No," to the boy because the consequences, should you become pregnant, aren't pleasant ones. If the answer is "No, there's no chance of my getting pregnant," it may be okay to have intercourse. Move on to the next question.

Question 2: Will I lose my reputation? If the answer's "Yes" or even "Possibly," then intercourse could be a pretty dangerous proposition. If the answer's "No, my reputation's absolutely safe," then it may be safe to go ahead. Move on to question 3. I might add that girls are more concerned about their reputations these days than many adults think. Virginity as such has little to do with reputation, but who the girl does it with, why she does it, and under what circumstances do have bearing on her reputation, and few girls are willing even today to be considered promiscuous or to have the boy talk about them.

Question 3: Will I be humiliated? Here the going gets tough for the girl. To the first two questions she can answer "No" pretty easily, almost off-handedly, but this one requires her to examine the nature of her relationship with the boy, what she expects of him, and how she will feel if he doesn't come up to these expectations. I recall one girl who was excitedly contemplating intercourse with a particularly status-conferring boy, but this question brought her up short as she realized his idea of status rested apparently entirely on his love 'em and leave 'em reputation. She decided she didn't want to feel the humiliation of acknowledging to herself that he had no use for her as a person but only as a "piece." If the answer to question 3 is "Yes" or "Probably" then intercourse is an invitation to the kind of hurt that most girls dread deeply. If the answer is "No" then intercourse might be a safe and gratifying experience. Try the last question.

Question 4: Will I feel guilty? This requires the girl to examine her own standards of sexual behavior, her religious convictions, her relations with her parents, her feelings about herself and her ideals. If the answer to this question is "Yes" or even "Possibly," going on to intercourse will create some problem for the girl and she knows it. She may be willing to take the risk but by this time she has at least done a lot of thinking about it, and engaging in intercourse can never again be wholly on the basis of impulse.

If she decides intercourse is safe for her, or that she's going to do it anyway despite the risks, then I would do everything I could to make sure that bad consequences would not occur — physically, emotionally, or socially. I would provide the chance for her to discuss the matter at

any time before or after her decision was implemented. I would try to assure myself that the risk of pregnancy was the least possible, including giving her whatever information she needed to get effective contraception.

What I advocate may sound to you like contributing to the delinquency of a minor. I don't think it is. No girl is going to engage in intercourse because a contraceptive is available. No girl who plans to engage in intercourse is going to change her mind because of the unavailability of one. The physician who takes a holier-than-thou attitude at that point and refuses to give a girl the information she needs to prevent catastrophe is party to the act, in my judgment, if she becomes pregnant. I wouldn't know how he could sleep very well after he heard the news. To act in the best interest of the girl seems to me the essence of being a good physician to her. How the physician who harms a girl by denying her what she needs to prevent disaster can justify his action is beyond me. Yet there are many who take such a view and condemn those who maintain that a girl who is going to have sexual intercourse premaritally should be provided with appropriate and effective contraceptive measures.

I think today's adolescents are going to come up ultimately with a new code of sexual morality based not on fear of parental or divine retribution because sexual pleasure is inherently evil but based instead on woman's right to sexual pleasure and on the ethics of interpersonal responsibility and commitment. Whether they do come up with a new code of this sort remains to be seen. Perhaps the ambivalences and conflicts and ambiguities our adolescents still haven't managed to work out for themselves will be transmitted to their children and create even more havoc in the next generation of adolescents. Certainly our generation has done little to help them resolve their conflicts since our own are so continually apparent. We, as a generation, don't know whether we want to adopt the "new morality" or not. Or perhaps it would be more accurate to say we would like to adopt it for ourselves while still totally committed to the old morality for adolescents.

At any rate, our own confusion leads us to present ambiguous cues to our adolescents — and the adolescents interpret this as insincerity, hypocrisy, and dishonesty. Quite clearly parents talk out of both sides of their mouths as they expound traditional moral values to their children and obviously espouse the different set being beamed into the house electronically. What teenager can believe his parents? The generation gap is at least partly explainable and understandable as a credibility gap.

Yet teenagers do need the benefit of the experience and knowledge of the older generation. Everything we know or believe isn't necessarily outdated. To make this experience and knowledge usefully available to an adolescent, though, we must win her trust. We must see things as they are — and tell it like it is — which includes, obviously, a multitude of potential dangers as well as a wealth of potential pleasure.

The family doctor, pediatrician or psychiatrist may be the only adults able to elicit this trust in the adolescent — and he has the obligation, in my view, to make himself available for the role of sexual advisor. He should not, of course, enter into a kind of mutual sex fantasy with the adolescent, but neither can he afford to live in his own fantasies if he is to be of service to the adolescent — either the fantasy that all sex is evil or the fantasy that all adolescents are sexually irresponsible. First and foremost, he is obligated to help his adolescent patient make the best possible decisions for herself, with the best information available, and to help her avoid harmful or undesirable consequences of her decisions, even if those decisions are not the ones he would have made for her.

● Dr. Sussex, Department of Psychiatry, University of Miami School of Medicine, P.O. Box 520875, Miami 33152.

I believe I've found the missing link between animal and civilized man. It is us.

Dr. Konrad Lorenz

EDITORIALS

Humanistic Operational Planning

Clifford H. Cole, M.D., M.P.H.

Nearly three years have passed since Florida's health professionals — and Florida's health — became the subject of an unhistorical experiment in management. An organizational abstraction having no administrative precedent was conceived and implemented; program planning was completely separated from program operations from the top to the bottom of the public health organization. The results were predicted by experienced public health administrators. Health professionals became prisoners of administrative process, slaves to a tyranny of paper. Required forms and minute detail multiplied beyond reason or conscience and program plans emerged unencumbered by the realities of daily operations. Health workers are discouraged.

There are more logical and proven principles to integrate planning and operations and protect them from the persistent aggressions of administrative process. Eons ago a far more effective organizational structure was devised. There exists in nature a model of the ultimate, utopian bureaucracy superbly designed for instant operational planning, immediate implementation of all things conceptually sound and supported by administrative services completely subservient to the mission of the organization.

Consider for a moment the human brain, that marvel of neurological organization, completely computerized, completely humanized. It is a perfect model for a modern day bureaucracy.

The brain resembles a huge walnut, with two large hemispheres, each the mirror image of the other and each controlling the movements and sensations of the opposite side of the body. All incoming information from the outside world — its sights, sounds and appearances — enters from below, and is reviewed on both sides of the brain simultaneously by means of a wide bridge of communicating fibers called the corpus callosum which connects each hemisphere with related areas on the opposite side. But the two hemispheres have one all important difference; each views the incoming data from opposite perspectives. The left is concerned with the active world of words, names, and numbers, of details and their ordered sequence. Methodical and dominating, it is the master of operations. The right hemisphere disregards detail to view the wholeness of things, their comprehensive meanings. It is thoughtful, creative and judgemental, the master of all planning and evaluation.

Occasionally, disease strikes the brain and the resulting disorientation serves to reveal the functional plan of nature's most perfect neurological organization. The corpus callosum can be largely destroyed, as by a stroke, and the hemispheres are effectively divided as one would separate two halves of a book. The ability to plan is effectively separated from the ability to operate.

The resulting human disarray is as predictable as it is distressing. Each hemisphere continues its specialized function deprived of simultaneous review of the same information on the opposite side. One is capable of operating but cannot interpret the plan; the other plans without the benefit of accurate data input. One hemisphere can identify objects by name but is unaware of their purpose; the other comprehends purposes but cannot name objects or communicate in verbal orders. Two different victims of such disease may behave in opposite fashions depending upon which hemisphere assumes leadership. For example, while one man would understand a verbal order to put on his pants, he could not comprehend how to do so and would show no

Dr. Cole is Director, Community Tuberculosis Control Services, Department of Health and Rehabilitative Services, Jacksonville.

embarrassment either for his ignorance or his nakedness; the other could not understand the order but would put on his pants voluntarily to avoid embarrassment! Needless to say, humans so affected are completely incapacitated, incapable of consistent, intelligent thought or action.

Soon the afflicted victim begins to vegetate, existing in a perpetual state of confusion, his elemental body functions being automatically controlled and dominated by lower centers of the brain concerned with supportive services. Breathing, digestion, the circulation of food and waste materials, and other administrative processes, become the major preoccupation and the victim withers in a useless expenditure of energy.

In the complex social world of institutional management, there are no perfect bureaucracies, but there are more valid principles for the conduct of operational planning than those now governing the organization of public health in Florida. Dedicated health professionals need not dissipate their energies in toil, tension, and discouragement, victims of their own organizational disease.

● Dr. Cole, P.O. Box 210, Jacksonville 32201.

Continuing Medical Education

Beginning its second century last fall, Meharry Medical College found itself right back where it started: Struggling for financial stability and trying to smile through it all.

In the wake of an eight year development drive that doubled the school's enrollment and faculty and added desperately needed facilities, the medical college recently found itself in debt and up against a severe cash-flow problem.

All Meharry employees making more than $10,000 a year were asked to take a 20% cut in pay, which was imposed in September and to end, hopefully, by November 1st. Student tuition had been raised from $2,700 to $4,000 but was still low by national standards.

Meharry, not just another medical school in a fiscal bind, has been called a "national resource" for it has given this country roughly one-half of its black physicians and dentists and a high proportion of black community leaders.

Meanwhile, the house staff at Meharry's Hubbard Hospital had intended to push for improved working conditions before the school's fiscal crisis intervened. Learning that the nurses involved in patient care were exempted from the 20% salary cut, the residents — many working 80 to 100 hours a week in patient care, were upset when told they must absorb the salary cut. The president-elect of the group, saying he could not afford a 20% cut in his $10,340 salary, resigned.

The residents, however, had considered striking but a majority reasoned that this would just add to the school's problems and so agreed to continue their long hours on reduced pay.

Should dedication-to-serving-others continue to be placed before seeking-financial-remuneration, as a part of the training program at Meharry, then 100 years from now, this school will still be producing medical practitioners whose patients will look to them with respect, confidence and love.

C.M.C.

One More Time — Let's Hear From You!!!

Our readers may wonder why another survey is contained in these pages for the second time in four months.

After we published the survey in the February 1978 issue, we leaned back and awaited a large number of responses. Unfortunately, it never materialized!

Out of the approximately 12,000 physicians who received the February issue, fewer than 300 physicians completed and returned the postage-free questionnaire. This is a most disappointing return!!!

Although some interesting trends emerged after analyzing the results of the first survey, the returns were too few to be conclusive. So, we try again in this issue.

The basic purpose of this survey is to gain information to help the editors make *The Journal* more informative and useful to FMA members. This time around, we would like to get at least 1,000 completed questionnaires back.

Won't you help us meet that goal? Even if you returned the February questionnaire, won't you take a couple of minutes now and turn to the green colored page toward the front of the magazine.

It will take less than five minutes of your time to aid us to help you.

AMA Advises Laetrile Users To Monitor Diets

Cancer patients who are taking laetrile should select carefully the foods they eat, a group of University of California researchers warn. Failure to do so could be fatal.

Laetrile, a derivative of apricot pits, has been the focus of much controversy. Its advocates claim it to be an effective cancer treatment, "even less toxic than sugar." Most medical authorities believe the compound is not effective and is potentially poisonous.

Writing in a recent issue of *The Journal of the American Medical Association,* the research team notes that many popular fruits and vegetables — including almonds and certain other nuts, lettuce, celery, peaches and related fruits, bean and alfalfa sprouts, among other things — contain chemicals called hydrolytic enzymes.

Laetrile, in turn, is chemically a cyanogenic glycoside. When cyanogenic glycosides come in contact with foods containing hydrolytic enzymes, the resulting mixture is hydrogen cyanide (HCN), a deadly poison.

HCN acts quickly, attacking the heart, brain and central nervous system. Within one to five minutes, the patient may experience difficulty breathing, have difficulty walking, have an urge to vomit, have convulsions, and lapse into unconsciousness.

If the dose of HCN has been sufficiently large, death may ensue within a matter of a few minutes to a few hours. In cases where the patient recovers, there are, at times, changes in personality a few days or a few months later.

Laetrile can yield an amount of HCN equal to about 6% of its own weight. One almond can release 48 mg. of HCN from laetrile, the JAMA report says.

ORGANIZATION



Louis C. Murray, M.D.

A Busy Year for Lou Murray, M.D.

Louis C. Murray, M.D., our 101st President of the Florida Medical Association, took office in May of 1977, following many years of service to organized medicine which uniquely qualified him for this honored and difficult position.

In taking the reins of office our President was faced with many and varied problems, some of which had lingered for many years and cried for solution.

Dr. Murray, with the assistance and backing of the Board of Governors and cooperation of the entire FMA executive staff, accomplished much this year. For years everyday FMA activities were carried out in Jacksonville and though this worked well, it was obvious that improvement could be had by opening satellite offices in heavily physician populated areas great distances from Jacksonville. This year, under Dr. Murray's leadership, regional offices were opened in the Miami area, in the Tampa area and the Capital office in Tallahassee was designated a regional office. Our President was a strong supporter of these moves and as the years go by we will reap the benefits of these wise decisions.

At the fall of Lou's gavel, a new headquarters building was purchased and eventually opened in Jacksonville. This will provide needed space, permit more efficient utilization of that space, and will undoubtedly result in a more modern and sophisticated administrative operation.

This past year Dr. Murray has traveled thousands of miles, not only to lead and participate in specific FMA activities, but also to attend the American Medical Association meetings, to meet with our FMA delegates in caucuses and advise them as appropriate. He also attended Blue Shield informational and board meetings, making himself and his staff available for input, and also taking information back that would be helpful to the leaders of the Medical Association.

He has also continued this year to involve himself deeply in the legislative activities, where he has perennially shown himself to be well equipped to use his own unique talents in dealing with legislators, members of the cabinet and department heads. His trips to Tallahassee and to Washington have led him down familiar hallways. We will recall those strong nominating speeches for this fine man two years ago and we are reminded that they were replete with statements and examples of his expertise in this area. This year has shown that he has continued to exercise these capabilities.

Lou has also carried on some of the tasks that were started by his immediate predecessors; e.g., our excellent public relations program of which we are proud, specifically referring to the FMA television film "It's Your Life," and the bimonthly radio and television programs called "Medical Message."

Our President has also adroitly presided over our Board meetings with his usual calm and dignified manner, and using his highly skilled talents in parliamentary procedure. I am sure that later when we look back on this year in FMA, under Lou's guidance and leadership, we will be grateful that the House has continued to be highly selective in it s election of leaders.

Joseph G. Matthews, M.D.
Orlando

Do all the good you can,
By all the means you can,
In all the ways you can,
In all the places you can,
At all the times you can,
To all the people you can,
As long as ever you can.

John Wesley

Countersuit Against Lawyers Won By Palm Beach County M.D.

A Palm Beach County physician has collected damages in a successful lawsuit against lawyers who had prosecuted a malpractice suit against him. It was the second time in less than a year that an FMA member had pursued a countersuit successfully.

A Palm Beach County Circuit Court awarded Sidney H. Burness, M.D., a Boca Raton cardiologist, damages of $15,000 plus court costs in a suit against the law firm of Miner, Tiernan and Gordon.

The law firm had represented a Canadian woman, Mrs. Margaret Trudel, in a $2 million suit against Dr. Burness and a Boca Raton hospital. Mrs. Trudel's husband, Robert, suffered a massive coronary in 1973 while visiting Florida. He later died after apparently leaving his bed to go to a washroom.

Mrs. Trudel's lawsuit later was thrown out of court.

Dr. Burness' countersuit charged that Mrs. Trudel's lawyers had failed to investigate properly and determine the truth or falsity of allegations that had been the basis of the Canadian woman's complaint.

Commenting on the award to Dr. Burness, his attorney, Charles H. Damsel, Jr., said: "I believe this judgment will be a deterrent to the inexperienced and unthinking lawyer who contemplates filing medical malpractice cases without justification or cause."

Last May, John B. Sullivan, M.D., of Fort Pierce, won a $175,000 verdict — later reduced to $75,000 by the trial judge — in a similar suit.

Dr. Jean L. Bennett Honored By Soroptimist International

Jean L. Bennett, M.D., of Clearwater, has been honored by Soroptimist International of Upper Pinellas County for her contribution to the community through medicine.



Dr. Bennett

President Carter and Senator Richard Stone sent congratulatory letters on the occasion.

Dr. Bennett's community responsibilities include the presidency of the Morton F. Plant Hospital Medical Staff, and leadership in childbirth and parenting classes. She is a past president of the Board of directors of the Child Guidance Clinic in Pinellas County.

Dr. Bennett serves on the Board of the Girl's Club, is a member of the athletic council of the high school her children attend, teaches sex education at two local schools, and has participated in numerous seminars at churches concerning sex education, parenting, and family and the child's response to death.

Florida Medical Association Blasts Government Report On Physician Fees

The Florida Medical Association has branded as misleading and inaccurate figures released by the Federal Government in March on physician fees.

FMA President Louis C. Murray, M.D., said the study by the White House Council on Wage and Price Stability "would have us believe physicians are at the top of the inflationary spiral."

In reality, he said, doctors' fees have increased an average of 6.2% a year since 1966, while the cost of maintaining a practice has gone up by about 8.3% annually.

Contrary to the Council report, the United States Department of Labor reports that physician incomes have increased less than those of teachers, attorneys, truck drivers and building tradesmen, Dr. Murray stated.

He charged that "the Federal Government is making political hay out of rising medical prices while blatantly ignoring increases in other areas."

FMA Asks Federal Court To Prohibit Medicare Payment Disclosure

The Florida Medical Association has asked a federal court to prohibit the U.S. Department of Health, Education and Welfare from releasing Medicare payment figures to the public.

The suit, filed in U.S. District Court in Jacksonville on March 24, seeks a permanent injunction against HEW and Florida's two Medicare intermediaries, Blue Shield of Florida and Group Health Insurance, Inc., of Miami.

The suit was filed in the names of Jere W. Annis, M.D., Louis C. Murray, M.D., Jack A. MaCris, M.D., O. William Davenport, M.D., Robert E. Windom, M.D., and Charles H. Beckert, M.D., on behalf of themselves and all Florida physicians.

FMA acted in the wake of HEW's announced intention to release Medicare payment data on or about April 30. The agency planned to announce Medicare payments made to physicians and directly to patients without making reasonable efforts to determine whether the information is accurate, FMA contended.

"This is a further attempt by the Federal government to invade patient privacy, intimidate an honorable medical profession, waste a tremendous amount of money, and contribute further to the cost of medical care provided by the government," FMA President Louis C. Murray, M.D., of Orlando, commented.

FMA contends that the proposed disclosure is not compatible with the purposes for which the information was collected; will constitute an abuse of discretion under the laws; and that such disclosure would violate the Privacy Act of 1974.

FMA also maintains that the information is confidential material relating to the private and personal financial or medical affairs of both physicians and patients; and should not be released without their consent.

In 1977, HEW issued a more restrictive list of Medicare payments to physicians only to recall it when the American Medical Association was able to document errors in almost two-thirds of the listings.

If the AMA didn't speak for the profession, who would?

Who would speak for the profession on the 2,500 health bills introduced in every Congress? Or the regulations issued by federal agencies?

Who would state the profession's views on national health insurance? Utilization Review Regulations? The Health Planning Act of 1974? Maximum Allowable Cost Regulations? Health Manpower?

Who would provide the scientific input and the practitioner's experience and knowledge so essential to legislation on drugs, cancer, heart disease, communicable diseases? Can you think of anyone?

The fact is, there is only one organization that can — and does — speak for the profession as a whole. The AMA.

It does so to protect the basic freedoms of medical practice in any federal health program that might be enacted, and even more important, to promote legislation for better health care for the entire public.

The AMA's voice can only be as strong as the members of the profession choose to make it. With your support, the AMA can be even more effective spokesman.



Join us.
We can do much more together.

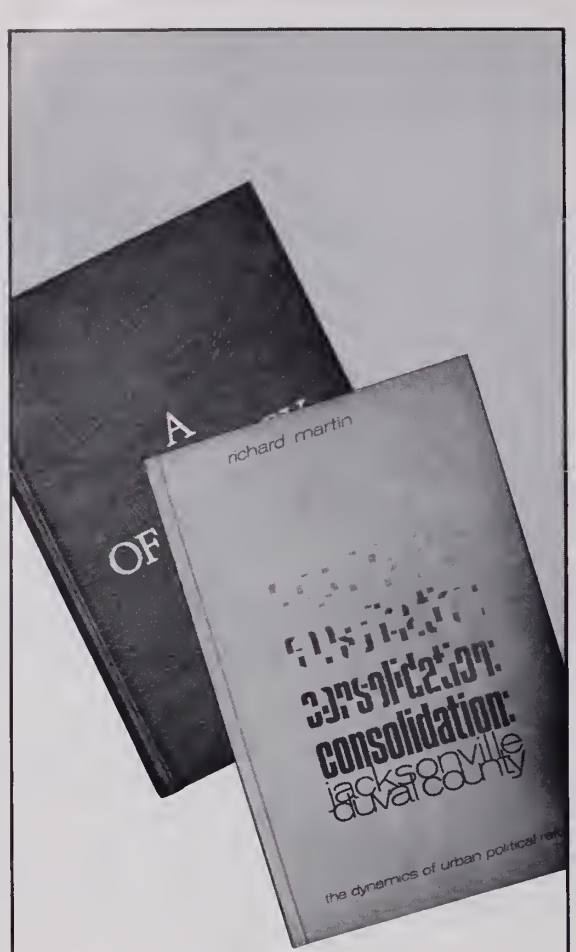
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BRIEF SUMMARY OF
PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

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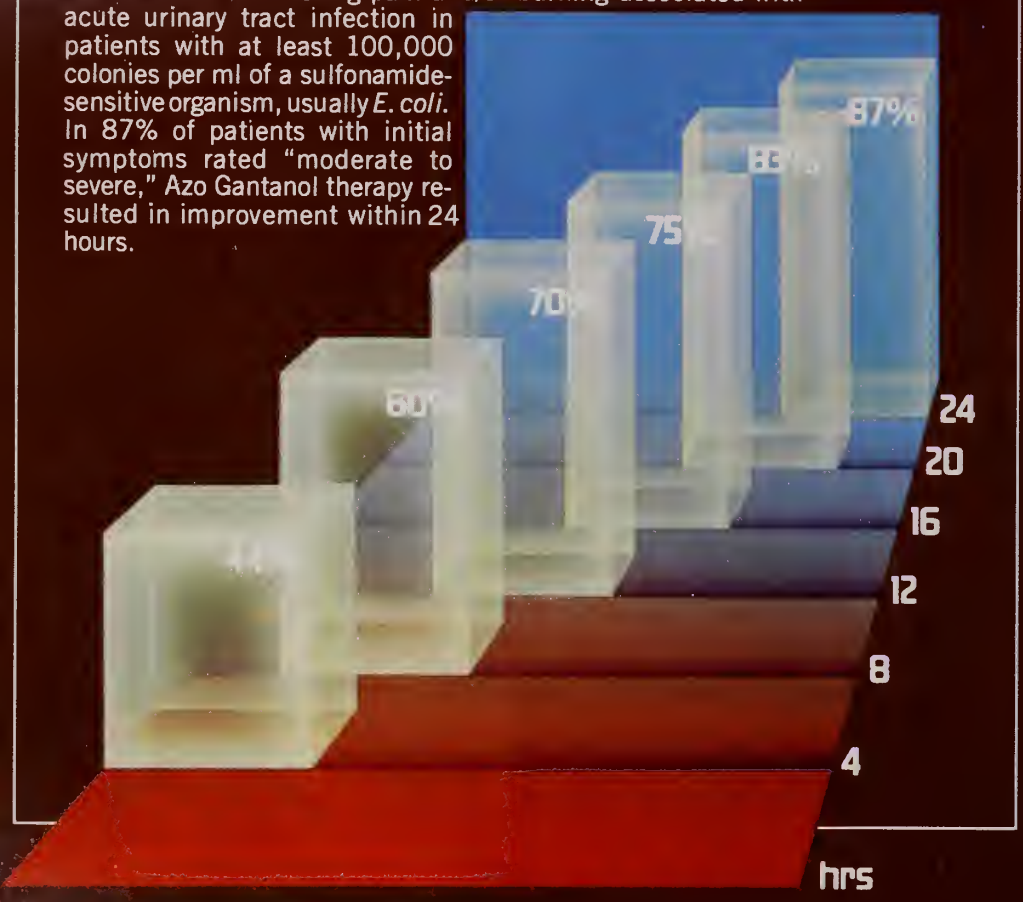
Please see brief summary of prescribing information on facing page.

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Important data on the pain of acute cystitis:

In 87% of patients studied [303 of 349], Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Before prescribing, please consult complete **uct information, a summary of which follows:**

Indications: In adults, urinary tract infection complicated by pain (primarily pyelonephriti pyelitis and cystitis) due to susceptible organ (usually *E. coli, Klebsiella-Aerobacter, Staph coccus aureus, Proteus mirabilis,* and, less f quently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: fully coordinate *in vitro* sulfonamide sensitivi tests with bacteriologic and clinical response aminobenzoic acid to follow-up culture medi increasing frequency of resistant organisms l the usefulness of antibacterials including sul fonamides.** Measure sulfonamide blood level variations may occur; 20 mg/100 ml should maximum total level.

Contraindications: Children below age 12; su fonamide hypersensitivity; pregnancy at term during nursing period; because Azo Gantanol tains phenazopyridine hydrochloride it is con dicated in glomerulonephritis, severe hepatit uremia, and pyelonephritis of pregnancy with disturbances.

Warnings: Safety during pregnancy not estab Deaths from hypersensitivity reactions, agran tosis, aplastic anemia and other blood dyscra have been reported and early clinical signs (throat, fever, pallor, purpura or jaundice) ma dicate serious blood disorders. Frequent CBC urinalysis with microscopic examination are ommended during sulfonamide therapy.

Precautions: Use cautiously in patients with paired renal or hepatic function, severe alle bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria stone formation.

Adverse Reactions: *Blood dyscrasias* (agran- ulocytosis, aplastic anemia, thrombocytopen leukopenia, hemolytic anemia, purpura, hyp thrombinemia and methemoglobinemia); *alle reactions* (erythema multiforme, skin eruptio Stevens-Johnson syndrome, epidermal necro urticaria, serum sickness, pruritus, exfoliativ dermatitis, anaphylactoid reactions, periorbi edema, conjunctival and scleral injection, ph sensitization, arthralgia and allergic myocard *G.I. reactions* (nausea, emesis, abdominal p hepatitis, diarrhea, anorexia, pancreatitis an stomatitis); *CNS reactions* (headache, periph neuritis, mental depression, convulsions, ata hallucinations, tinnitus, vertigo and insomni *miscellaneous reactions* (drug fever, chills, t nephrosis with oliguria and anuria, periarteriti nodosa and L. E. phenomenon). Due to certa chemical similarities with some goitrogens, d uretics (acetazolamide, thiazides) and oral h glycemic agents, sulfonamides have caused r instances of goiter production, diuresis and h glycemia. Cross-sensitivity with these agents exist.

Dosage: Azo Gantanol is intended for the acu painful phase of urinary tract infections. *Usu adult dosage:* 2 Gm (4 tabs) initially, then 1 (2 tabs) B.I.D. for up to 3 days. If pain persi causes other than infection should be sought After relief of pain has been obtained, contin treatment with Gantanol (sulfamethoxazole) r be considered.

NOTE: Patients should be told that the oran dye (phenazopyridine HCl) will color the urin

Supplied: Tablets, red, film-coated, each co ing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 50

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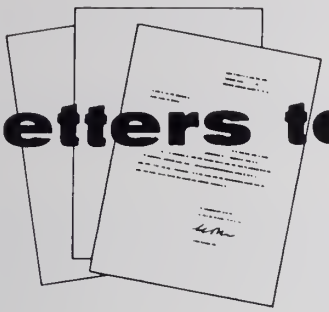
Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain

for the pathogens

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110.



Letters to the Editors

Hon. Andy Ireland, of Florida
in the House of Representatives
Tuesday, January 31, 1978

Mr. Ireland: Mr. Speaker, I have submitted the following remarks in written rather than oral form in order to avoid tying up the House's time for discussion.

Dr. Robert E. Windom, a distinguished physician from Sarasota, Fla., has sent the following letter to HEW Secretary Califano and has made a copy available to me.

I am impressed with Dr. Windom's letter and disturbed by the problems he enumerates. For, as he points out, these problems are not unique to him.

At a time when we are all concerned with rising health costs and the burden of overregulation, I wanted to take this opportunity to share Dr. Windom's concerns with my colleagues:

Sarasota, Fla.
January 11, 1978

Joseph A. Califano,
Secretary,
Department of Health, Education, and Welfare,
Washington, D.C.

Dear Mr. Secretary: I am dictating this letter to you on a Saturday as I sit at my desk doing some of the unnecessary paperwork caused by rules and regulations from government channels. I feel compelled to call this matter to your attention because it may have a personal effect on me later.

Part of this paper work is the endorsing of eleven checks which were made payable to me through the Medicare intermediary in Florida. These checks are not due me, but because of the system they have been made out in my name. Therefore, I call to your attention that when you accumulate figures for physician's income you specifically look at my listing, and take into consideration that for the past eleven months erroneous allocations have been made in my name. The checks I endorse today are only eleven but come to $274.20. These are just a small number of the hundreds that I have had to endorse through the year, therefore, I am certain that the amount will be quite significant. Also, I am not the only physician affected by this system.

The reason I have to do this is because of a requirement that was placed upon the intermediary in January of 1977 which changed a computer program. This in turn affected the computer billing done from the local area. I, personally, along with my office manager have spent considerable time during these eleven months discussing this with representatives of Blue Shield on the state and local level and with the local computer billing service. As a result of this eleven month discussion, the situation remains the same. By no means am I an expert in computers. However, I understand that the experts yet have not been able to adapt a program procedure to meet the federal requirements, nor those of the Internal Revenue Service. For eleven previous years the billing program was working well for our group of physicians who interpret electrocardiograms. Because of certain new regulations, changes occurred which resulted in a system creating much extra work, time, and significant financial involvement for those concerned. For example, my office manager has spent many hours during the past year working on this. Her salary is paid entirely by me, yet I receive no compensation to pay her for this extra work. This has also consumed a considerable amount of my professional time which could have been well spent for patient care or, when possible, to enjoy some free time of my own. Would you think that it might be proper for the federal government to reimburse private citizens for the service they render as a result of government regulations? Is it proper to expect patients to pay for this service which adds unnecessary expense to their health costs?

Mr. Secretary, this is just one of the many glaring examples of problems created by government intervention into the field of health care. I read almost daily about comments about how "fat" the hospitals are in our country, how the great majority of physicians are overpaid, yet I do not see statistics justifying these quotations in any fair or equitable manner. Nowhere have I seen any remarks by you praising the great number of physicians, plus others in professional health fields, who are making efforts daily to provide the best

Dr. Windom is Secretary of the Florida Medical Association, Inc.

care possible at the most reasonable cost. If a proper analysis were made, it is very possible that this group would be the great majority.

It is relatively easy for a general to direct a war many miles away from the battlefront. However, no one really knows what goes on until he is a part of the front line. This analogy is no different from that of your position as a leader for health. If you continue to direct this area as you have, I urge you to develop a cadre of front line physicians throughout the country who can tell you the story as it is — not to have you misled by those who never have been actively involved in direct patient-physician relationships, thus not knowing what is involved in the actual delivery of medical services.

I feel certain that I am only one of many physicians in this country who are adversely affected financially, as far as reporting is concerned, by the system that I have described. This letter is to clarify the issue in my own personal situation so that you will have advance knowledge should the figures from my income meet your criteria for publication.

Very truly yours,
Robert E. Windom, M.D.

Reprinted from the Congressional Record, January 31, 1978.

Dear Gerry:

Just a note to formally endorse the praise and congratulations that I tried to convey to you when we last met regarding the current issue of the Journal of the Florida Medical Association. It is outstanding professionally and a superbly executed publishing effort. In my work in the FMA and in my travels around the country I have seen many editions of medical journals but this most recent effort of yours is far and away the best that I have ever encountered. It is truly a masterful job and you and your staff are to be congratulated.

The idea of sending it out to all the medical students in the state was a real inspiration. I am sure that every student will read it avidly and at the same time, perhaps unconsciously, absorb the fine public relations message from the Florida Medical Association and Organized Medicine in general that is contained in the gesture.

All of us are indebted to you for a job that surpassed your own unusually high level of industry and excellence.

Sincerely,

J. W. Annis, M.D.
Lakeland

Dear Sir: I am a physician of Romania. I am working as a lecturer at the Medical Department of Cleej-Napoca University.

I have read your journal and I was impressed by its high and valuable standard of specialty problems discussed.

As I cannot afford to regularly buy it, I should be very grateful if you would consider my name on the list of gift books. My address is D'goia Aurel, M.D., Ph.D., 3600 Cleej-Napoca, Romania.

Dear Editor: Kudos to all of you at the Journal of the Florida Medical Association on your plans to distribute a copy of the special issue (March) "Adverse Reactions to Plants in Florida" to all medical students and residents in Florida.

I believe this is a step forward in encouraging the young physicians in our state to participate in organized medicine and to reap some of the benefits from their necessary involvement.

I'm sure all the young physicians of Florida appreciate the efforts of your staff.

Sincerely,
Michael L. Steiner, M.D.
President, Florida Chapter
American Academy of Pediatrics and Florida Pediatric Society

Dear Dr. Schiebler:

Congratulations on the excellence of the March issue of the Journal. You deserve to get many letters of appreciation.

It would be delightful if the Florida Medical Association would grow in demonstrated quality of medical performance until its "Journal" becomes tops, or near tops, in the nation.

Too often we have concerned ourselves with money to the exclusion of subjects helpful to good medical practice. Let's continue to make a change for the better.

All good wishes to you and your staff.

Yours truly,

J. Wilfred Davis, M.D.
Maitland

Gerold Schiebler, M.D., Chairman
Department of Pediatrics
J. Hillis Miller Health Center
Gainesville, FL 32610

Dear Gerry:

I have just finished going through the March 1978 Issue of the Journal of the Florida Medical Association.

What a super edition! This is certainly a very valuable contribution to the knowledge of toxic plants in Florida and will be very helpful to those of us in front line pediatrics. I will keep it immediately available in my office and file right next to the April 1968 issue, when Thad was the editor and concerned with snake bite. These will be very handy reference sources when we need to know some facts in a hurry.

I have resigned from all future yard work because, after reading the March Journal, I have become aware of so many phytotoxins in our own yard that I am afraid to go out of the house for fear the poinsettias will gobble me up, and I won't be able to call for help because of a mouthful of dumbcane.

Congratulations on a super job!

Sincerely yours,

James C. Lanier, M.D.
Jacksonville

Dr. L. E. McHenry
1341 South Hickory Street
Melbourne, Florida 32901

Dear Dr. McHenry:

I have just received a copy of the March issue of the Journal of the Florida Medical Association and I wish to congratulate you and your colleagues in achieving this milestone. It is a significant contribution toward more general professional knowledge of potential sources of human injury, and I feel that all associated with the production of this issue have performed a great public service.

Just a moment ago, I came upon — with much surprise and pleasure — your generous review of MAJOR MEDICINAL PLANTS. I thank you heartily and am sure the publishers will be delighted to have the book reviewed in this special issue of the Journal. I shall send Charles Thomas a photocopy of p. 226.

I hope that I may have a few more copies of the Journal (besides this one) — for distribution here at the University and one for my good friend, Dr. Erich Hecker, Director of the Institut for Biochemie, Deutsches Krebsforschungszentrum, Heidelberg, who is making the special study of co-carcinogens in the Euphorbiaceae.

Yours sincerely,

Julia F. Morton, D.Sc.,
Research Associate Professor
Director, Morton Collectanea
Miami

Laudie E. McHenry, M.D.
1341 South Hickory
Melbourne, Florida 32901

Dear Mac:

I have just received the March issue of the Journal of the Florida Medical Association and I want to congratulate you on this outstanding issue.

I have read it with great interest and am placing it in our home so it will be readily available to both Ruth and me.

Sincerely yours,

F. C. Coleman, M.D.
Tampa

Gerold L. Schiebler, M.D.
Editor
The Journal of the Florida Medical Association, Inc.
P. O. Box 2411
Jacksonville, Florida 32203

Dear Gerry:

I am enclosing a copy of a note to Laudie McHenry about the March issue of the Journal of the Florida Medical Association.

I want to congratulate you also on this outstanding issue and to tell you what a fine job you are doing as Editor of the Journal.

Sincerely yours,

F. C. Coleman, M.D.
Tampa

Laudie E. McHenry, M.D.
1341 South Hickory Street
Melbourne, Florida 32901

Dear Laudie:

The March, 1978 issue of the Journal of the Florida Medical Association was magnificent.

You have organized a marvelous contribution to the literature.

Cordially,

Jerome Benson, M.D.
Miami Beach

Laudie E. McHenry, M.D.
1341 South Hickory Street
Melbourne, Florida

Dear Laudie:

This note is to congratulate you upon the special issue of the JFMA, "Adverse Reactions to Plants in Florida."

You have done a magnificent job. This issue is not only aesthetically attractive but very practically useful and should be in every hospital emergency room and primary practitioner's office.

Again, congratulations.

Sincerely,

William M. Straight, M.D.
Miami

E. Charlton Prather, M.D.
Associate Editor

Dear Dr. Prather:

This is to extend my appreciation to you, Dr. Schiebler, Dr. Collins, Dr. McHenry, Dr. Blank, Mrs. Rader and Mr. Hagan and any others particularly involved in the preparation and publication of the March, 1978 issue of the Journal of the Florida Medical Association. It is extremely informative as well as pictorially striking. I'm sure it will be useful to all concerned with plant poisons for many years. It certainly fills a great need.

Again, my congratulations and my thanks for an outstanding issue.

Sincerely,

Emily H. Gates, M.D.
Health Program Office
Tallahassee

Florida Medical Association
Jacksonville, Florida

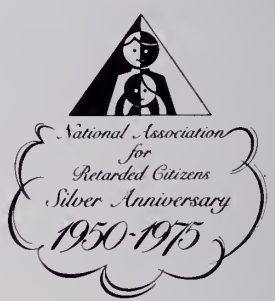
Dear Editor:

As a medical student at USF, I would like to thank you for myself and for all the students at our school for your generous Special Issue on Adverse Reactions to Plants in Florida.

This is an attractive and informative Journal and we appreciate your thoughts. We also appreciate your invitation to become involved in the FMA, as many of us do plan to practice in Florida.

Thank you again.

Christine McCarty
USF College of Medicine
Tampa



There are more than six million retarded Americans.

For a long time, nobody cared.

It's different now. Because twenty-five years ago, the National Association for Retarded Citizens was founded as a voluntary agency devoted to promoting the welfare of retarded children and adults.

Today it's more than 1700 local and state member units are working to ensure educational and job opportunities and residential and treatment programs so mentally retarded individuals can participate in community activities. They need your help and understanding.

Support your local member unit of the National Association for Retarded Citizens.

For information, write:

National Association for Retarded Citizens
2709 Ave. E. East, Arlington, Texas 76011
Area Code: (817) 261-4961



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

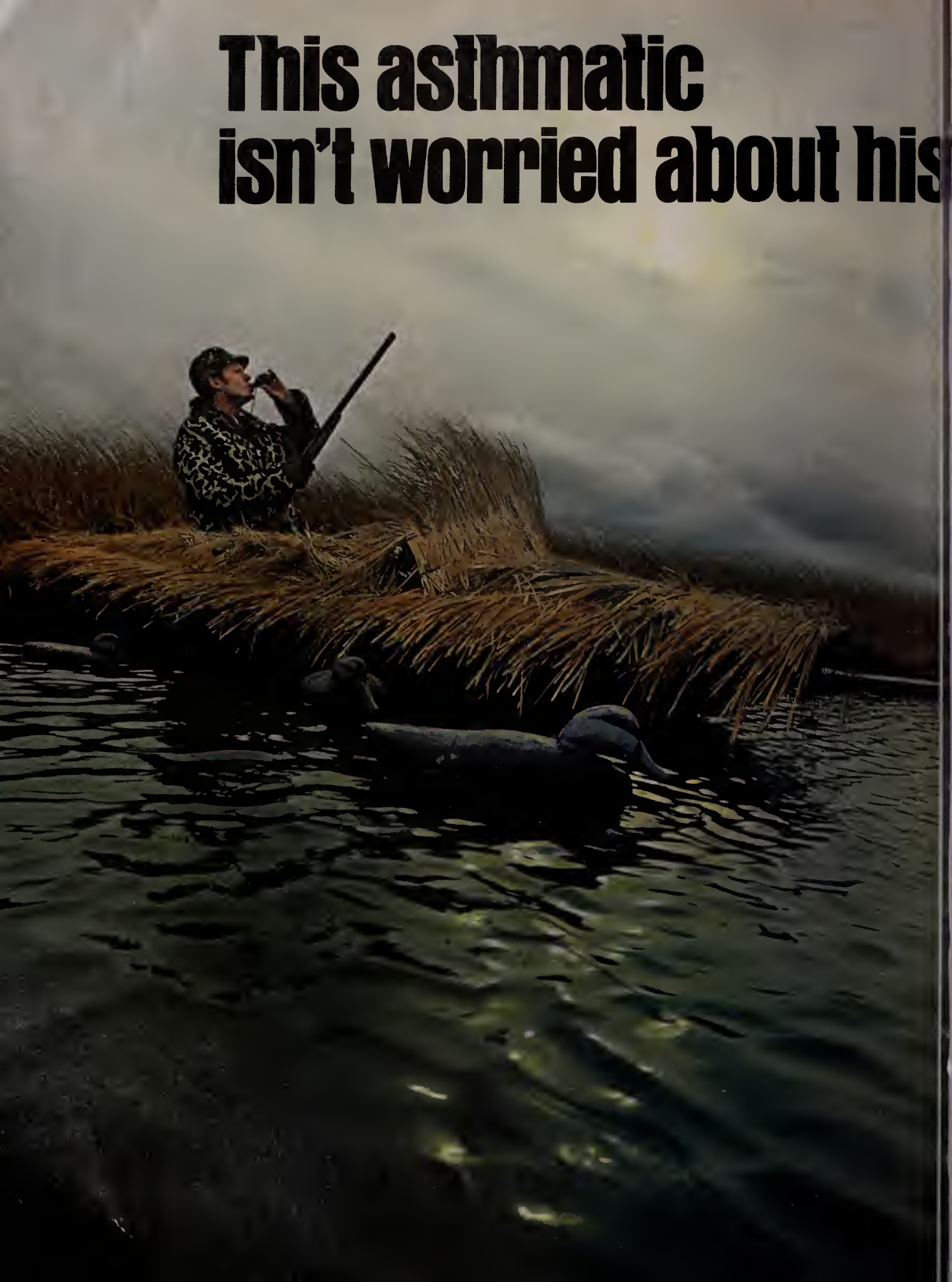
U.S. Pat. No. 3,056,836

VASODILAN®
(ISOXSUPRINE HCl)
20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

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This asthmatic isn't worried about his



next breath...

he's active
he's effectively
maintained on

QUIBRON®

Each capsule or tablespoonful (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

high theophylline for effective around-the-clock therapy

Quibron may give the asthmatic up to eight hours of bronchodilation with each dose and provides the high dosages of theophylline which are now believed necessary to keep patients free of acute attacks and chronic wheezing.

100% free theophylline

Quibron helps achieve high serum theophylline levels with minimal dosage volume...delivers 100% free theophylline in comparison to many other compounds which contain from 47% to 91% effective theophylline.

individualized theophylline dosage schedule

Today's more efficient usage of theophylline includes individualizing dosage and monitoring serum theophylline levels. The usual recommended dosages of Quibron are: Adults—1 to 2 capsules or tablespoonfuls every 6 to 8 hours; dosage may be cautiously adjusted upward when necessary to a maximum of 2000 mg theophylline per 24 hours. Children under 12—4 to 6 mg theophylline per kg/body weight every 6 to 8 hours; dosage may be cautiously adjusted up to 9 or 10 mg/kg every 6 hours.

Now, for the asthmatic who requires high-dose theophylline therapy for therapeutic serum concentrations

Mead Johnson Pharmaceutical Division announces

QUIBRON®-300

Each capsule contains 300 mg theophylline (anhydrous) and 180 mg glyceryl guaiacolate (guaifenesin)

For Brief Summary, please see the last page of this advertisement.

QUIBRON®-300

Each capsule contains 300 mg theophylline (anhydrous) and 180 mg glyceryl guaiacolate (guaifenesin)

The new high-dose theophylline capsule... for dependable theophylline therapy when products of lower dosage do not adequately control asthma symptoms.

Specially formulated

...for optimal efficacy

Quibron-300 is appropriate therapy for asthma patients whose symptoms are not adequately controlled on lower doses of theophylline, particularly for patients whose theophylline dosage has been adjusted upward to achieve therapeutic serum levels. In one study,[1] an average peak increase in FEV_1 of 35% was demonstrated after a single dose equivalent to one Quibron-300 capsule, and significant improvement in this pulmonary function lasted for nearly eight hours after administration.

...for optimal predictability

One Quibron-300 capsule q6–8h yields therapeutic serum levels (10–20 mcg/ml) in many adults. With a single dose, more than 75% of patients achieved serum levels potentially providing clinical benefit (5–15 mcg/ml). Half-life of theophylline varies widely from patient to patient, making monitoring of theophylline therapy important. Patient response may be monitored clinically if blood levels are not available as long as dosage does not exceed 1200 mg in 24 hours for adults.

...for optimal dosage convenience

The simple, convenient dosage of new Quibron-300—one capsule every six to eight hours—makes it easy for patients to comply with high-dose regimens often required to achieve therapeutic serum levels. Quibron-300 capsules may provide maximum therapeutic value with maximum convenience. In fact, the switch from a low-dose to a high-dose regimen may be accomplished by merely switching capsules, by stepping up to Quibron-300 capsules.

...for minimal theophylline side effects

Adverse reactions to theophylline are related to serum levels and are usually not a problem at concentrations below 20 mcg/ml. Of 45 patients studied[1] after a single dose, only seven reported adverse reactions. The most common reaction was a feeling of lightheadedness by three of these seven patients.

Reference 1. Data on file. Mead Johnson Pharmaceutical Division.

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.

Dosage: Quibron—Adults: 1–2 capsules or 1–2 tablespoonfuls elixir every 6–8 hours. Children under 12: 4–6 mg theophylline/kg body weight every 6–8 hours.

Quibron-300— Adults: 1 capsule every 6–8 hours.

Theophylline dosage may be cautiously increased to 2000 mg/24 hour in adults and 9 or 10 mg/kg every 6 hours in children. Monitoring of serum theophylline levels at higher dosages is recommended.

Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

How Supplied: Quibron Elixir: Bottles of 1 pint and 1 gallon. Quibron Capsules: Bottles of 100 and 1000 and unit-dose packs of 100. Quibron-300 Capsules: Bottles of 100.

Mead Johnson PHARMACEUTICAL DIVISION

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MJL 7-4280



Jack A. MaCris, M.D., of St. Petersburg . . . Past President of the Florida Medical Association, participated as a panelist in a program on "Ethical Decision-Making in Health and Medical Care Management in Florida," at the University of South Florida College of Medicine on March 16.

The panel in which Dr. MaCris participated was on "The Role of the Health and Related Professions in the Promotion of the Balance Between Individual Rights and the Public Interest in Florida." One of the other panelists was William J. Page Jr., Secretary of Florida's Department of Health and Rehabilitative Services.

The Florida Medical Political Action Committee (FLAMPAC) . . . has won 1977 membership achievement awards in four categories, according to an announcement by the American Medical Political Action Committee (AMPAC).

AMPAC Chairman Rex E. Kenyon, M.D., advised FLAMPAC Chairman John W. Glotfelty, M.D., of Lakeland, that FLAMPAC turned up in first place among state PACs in the sustaining membership category.

Dr. Kenyon also said FLAMPAC was second in all events, second in ratio of members to potential, and third in largest increase over prior year category.

Gerard F. Carter, M.D., of Miami . . . has been named President of the Section on Allergy and Immunology of the Pan American Medical Association. Dr. Carter, a pediatric allergist, has been serving as North American Chairman of the group.

Louis M. Perez, M.D., of Sanford . . . has been appointed to the AMA's ad hoc Committee on Foreign Medical Graduate Affairs. Well known in Florida, Dr. Perez received the Benjamin Rush Award at the AMA House of Delegates Meeting last December, and seven years ago at the Florida Medical Association Annual Meeting he received the A. H. Robins Company Award for Outstanding Community Service by a Physician.

Michael Schwartz, Ph.D., of Buffalo, N.Y. . . . became Dean of the University of Florida's College of Pharmacy in April.

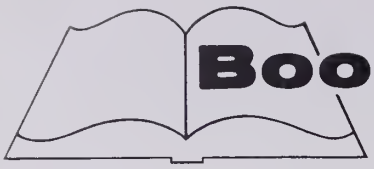
Dr. Schwartz has been Professor of Pharmaceutics and former Dean of the School of Pharmacy at the State University of New York, where he introduced a Doctor of Pharmacy program in 1971.

Dr. Schwartz succeeds Kenneth Finger, Ph.D., who relinquished the deanship last year to become full-time Associate Vice President for Health Affairs at the University of Florida.

The Liaison Committee on Continuing Medical Education . . . has announced the reaccreditation of the CME program at Halifax Hospital Medical Center in Daytona Beach for another three years.

Accreditation enables the hospital to sponsor or co-sponsor continuing medical education activities offering American Medical Association Category I Credit. In 1974, Halifax became the first agency in Florida offering CME to be accredited as a result of a survey conducted by the FMA Committee on Continuing Medical Education.

It was resurveyed late last year, and reaccreditation was granted on the recommendation of the FMA CME Committee.



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

A Woman's Choice by Samuel J. Barr, M.D. with Dan Abelow. 306 Pages. Price $10.95. Rawson Associates Publishers, Inc., New York, 1977.

The drama and saga of the abortion issue is very well presented by Dr. Barr and his co-author. The personal experience of having successfully handled over 20,000 patients desiring termination of pregnancy certifies Dr. Barr to be very knowledgeable in the medical, emotional and legal aspects of abortion. The sensitivity, compassion and skill with which Dr. Barr has presented the results of his experience is impressive. The layman and the physician alike will become involved and identify with the women of all ages and circumstances who tell their stories on the pages of **A Woman's Choice.**

The recurrent theme and plea of the book is that every woman be given the right to arrive at a decision with which she feels secure, pursues her choice without guilt, terror or shame; and that the outcome be the best possible one for everyone. The appendices present much factual data in both the medical and political aspects of the abortion question.

You will not agree with everything Dr. Barr presents, but one thing is for sure: one cannot finish without dealing with his own feelings about the abortion issue.

J. Lee Dockery, M.D.
Gainesville

Dr. Dockery is Associate Professor, Department of Obstetrics and Gynecology, University of Florida College of Medicine, Gainesville, and Vice President of the Florida Medical Association.

Self-Rescue by John Kiley, Ph.D. 222 Pages. Price $7.95. McGraw-Hill Book Company, New York, 1977.

This book is a provocative counterattack against anguish and unhappiness; it runs the gamut from overcoming loneliness, boredom, surviving a tragedy, forgetting a painful past, to building a constructive future.

In an introduction by William F. Buckley Jr., Mr. Buckley states, "Self-Rescue eschews familiar methods of stimulation, manipulation and analysis: its emphasis is on harmony with the nourishing and sustaining things and avoiding absorption in the lethal thought. If Dr. Kiley demands courage of the reader, he also reminds him serenely that the resources of courage are simply there, for whoever truly desires them . . . Kiley speaks without a syllable of the oppressive jargon of the established psychologies."

This book speaks to your needs and instincts philosophically and psychologically. The author urges you to forget pop-fads, instant gurus and trendy therapies and look within yourself for the answers to your problems. There are chapters on how to take charge of yourself and do what you really want to do; how to master time; how to trust yourself; how to forget the past; how to be cheerful, brave and how to find yourself — and many others.

While it may not change your life, it's interesting reading.

L.R.

Life is easier to take than you'd think; all that is necessary is to accept the impossible, do without the indispensable, and bear the intolerable.

—Kathleen Norris

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Labor & Delivery, An Observer's Diary by Constance A. Bean with an introduction by Gerald Cohen, M.D. 203 Pages. Price $7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

The Nervous System by William F. Ganong, M.D. 226 Pages. Illustrated. Price $8.00. Lange Medical Publications, Los Altos, California, 1977.

Handbook of Pediatrics by Henry K. Silver, M.D., C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 723 Pages. Price $9.00. Lange Medical Publications, Los Altos, California, 1977.

Nothing to Fear, Coping With Phobias by Fraser Kent. 204 Pages. Price $7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Clinical Cardiology by Maurice Sokolow, M.D. and Malcolm B. McIlroy, M.D. 659 Pages. Illustrated. Price $16.00. Lange Medical Publications, Los Altos, California, 1977.

Medical Aspects of the Imported Fire Ant by Robert B. Rhoades, M.D. 75 Pages. Illustrated. Price $4.75. The University Presses of Florida, Gainesville, 1977.

Occupational Diseases: A Syllabus of Signs and Symptoms by E. R. Plunkett, M.D. 352 Pages. Price $22.50. The Barrett Book Company, Stamford, Connecticut, 1977.

Current Medical Diagnosis & Treatment by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1098 Pages. Price $17.00. Lange Medical Publications, Los Altos, California, 1978.

Diabetic Menus, Meals and Recipes by Betty M. West, revised by Nancy Greene Eash, M.S., R.D. 194 Pages. Price $7.95. Doubleday & Company, Inc., New York, 1978.

The Compulsive Overeater, Seven Steps To Thin Sanity by George F. Christians. 100 Pages. Price $5.95. Doubleday & Company, Inc., Garden City, New York, 1978.

DNA Repair Processes, Edited by Warren W. Nichols, M.D. and Donald Murphy, Ph.D. 286 Pages. Illustrated. Price $29.95. Stratton Intercontinental Medical Book Corporation, New York, 1977.

Current Pediatric Diagnosis & Treatment, 5th Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1102 Pages. Illustrated. Price $17.00. Lange Medical Publications, Los Altos, California, 1978.

Ode to Thanatos

O Thanatos, I sing of you
Prince of Peace
Son of Nyx, I cannot cease
To proclaim the praises that are your due.
Your brother, Hypnos, brings restful sleep
But only you can return the soul to the deep.
When on the wards, I wend my way
And behold the suffering day by day,
I know that you wait in the wings
To bring peace to beggars and to kings.
I know that although you roam,
You will be there to bring them home.

When malignant cells destroy the breast
When malignant cells destroy the brain
When every breath brings constant pain,
You will be there to bring them rest.
You were there with my father in his tent
You were there when my mother went.
You brought an end to their suffering
You brought them to their heavenly King.
Although I wept at their loss,
I give you thanks O Thanatos.
For bringing peace to those who suffer,
My gratitude to you I offer.

When I was young,
To Eros songs were sung.
We gave no thought to death.
We lived with every breath.
To life we clung
We fought disease and we fought woe.
We considered Thanatos our foe.
But as the years passed by
And our wisdom grew
With it came a sigh
And a glimmer of what was true.
Thanatos was not all bad.
It's true at times he stung
And we were sad.
But we held our tongue
***For** we knew that in the end*
***Th**anatos was our friend.*

We are grateful to the author of this poem, Louis Alper, M.D., of Coral Gables, for submitting it to The Journal.



Others Are Saying

Reading List For A Medical Housewife

Betty Vickers

Recently, while sorting out a stack of Ladies Home Journals, Time Magazines, Southern Living, and Saturday Reviews, I discovered a stray copy of the New England Journal of Medicine. A note was scribbled on the cover: "See article by Norman Cousins, p. 1458.

I was dumbfounded. Had a favorite literary personality transferred his allegiance to the world of medical journalism? Regardless of the fact that it was time to start preparations on a gourmet meal for a very favorite gastroenterologist, I dropped everything and dashed to page 1458. And there is was "Anatomy of An Illness" by Mr. Saturday Review himself, Norman Cousins.

What Mr. Cousins had to say was mind boggling. His story about his personal illness and his unconventional method of coping with it was the beginning of a literary adventure for me. I couldn't get to the library fast enough to check out the first of his list of references, Smith, Adam, "Powers of Mind."

Several years ago Mr. Cousins had travelled to Russia on a cultural mission for the U.S. Government. It was an emotionally and physically fatiguing trip.

Shortly after his return, he became seriously ill with a condition that was ultimately diagnosed as Ankylosing Spondylitis. His chances of recovery were 1 in 500. Faced with such depressing odds Mr. Cousins felt he could do no worse than his physicians in trying to locate a cure; so he set out to do a little bit of detective work.

He explored such works as Walter Cannon's "The Wisdom of The Body" and Hans Selye's "The Stress of Life." He did such innovative things as move out of the hospital into a hotel — an environment much more conducive to getting well.

Impressed with the idea that a good belly laugh has more therapeutic value than a bottle of pills, he had regular showings of some old candid camera films and heavy doses of E. B. White's "Subtreasury of American Humor."

There are many more details to the saga of Mr. Cousins. Suffice to say he recovered and returned to the world of the Saturday Review.

My adventure, however, continues. Adam Smith's book suggested a whole new set of fascinating references to check out at the library. Some, I discovered, are even available at the paper back book rack at the supermarket!

"The Relaxation Response" by Herbert Benson, M.D., had some super ideas about how to cope with anxiety by a relaxation technique. It's sort of a western form of Yoga. It has been very helpful.

I no longer worry about grocery shopping, cooking, carpools, etc., etc.

I am not sure if my husband has responded to all this as enthusiastically as I have. I think I heard him mutter while he loaded the dishwasher this A.M., "That's the last time I'll bring home a New England Journal."

(1. Cousins, Norman, Anatomy of an Illness (As Perceived by the Patient), New England Journal of Medicine 295: 1458-1463, 1976.)

Reprinted from the May 1977 issue of the Escambia County Society Bulletin. Betty Vickers is a former nurse-educator and the mother of three teenagers. She is married to a Pensacola gastroenterologist. She and her husband, Norman, were contributers to the 1974 JFMA Centennial Issue; their article was entitled "Notations on Pensacola's Medical History, 1873-1923."

Marital Problems Within the Medical Profession

Daniel B. Nunn, M.D.

"Marriage resembles a pair of shears, so joined that they cannot be separated, often moving in opposite directions, yet always punishing anyone who comes between them."

Sydney Smith

Last November, Dr. Thomas B. Thames of Orlando, a member of the Florida Medical Association Board of Governors, was the guest speaker at the scheduled meeting of the Duval County Medical Auxiliary. Although Dr. Thames (Byron) is well known as a successful physician and a highly capable, diligent, effective member of the FMA leadership, it was not these qualities or position which prompted his invitation to speak. On the contrary, it was Byron's captivating address entitled "Stress and Strain of a Medical Marriage" presented at the 1976 State Auxiliary Fall Conference. It is my understanding that the Duval County Auxiliary members in attendance were so titillated by the *tell it like it* is talk that they not only rushed out to purchase copies of *The Joy of Sex* but quickly decided in favor of a repeat performance by Byron at the local level.

As official liaison representative between the County Medical Society and its Auxiliary (in other words, the Auxiliary president's husband), I was given to understand that I should attend the meeting. Since I obediently acquiesced and was the sole male present with the exception of the speaker, it seems only appropriate that I offer my impressions and comments regarding Byron's presentation to the ladies of our Medical Auxiliary. For those unacquainted with the details of the talk, I refer you to Dr. Thames' paper published in the February, 1977 issue of the Journal of the Florida Medical Association and to the excellent newspaper article by Sydney Parsons which appeared in the November 23, 1977, edition of the Florida Times-Union.

Without question, the November meeting of the Duval County Medical Auxiliary can only be described as a smash hit! Advance publicity was obviously as manifested by the unusually large attendance of wives most of whom openly expressed their eagerness to hear a candid discussion of medical marital problems. During the talk, it was somewhat amusing to observe the frequent nodding of heads signifying approval whenever the speaker alluded to marital difficulties related to a doctor's ego, inadequate attention to his spouse's sexual desires, and failure to accept women as individuals with equal rights. On the whole, the ladies of the Auxiliary exemplified a keenly attentive group; however, it was clearly apparent that the majority left with the distinct impression that the doctors needed this type educational program much more than their wives.

Having contemplated the subject at hand, I wish to express (admittedly with trepidation) certain views which I consider important to the continuing well-being of a medical marriage. Since I learned a lot from Byron Thames, he should be credited for any similar views previously presented by him. To begin, it is my opinion that the exigencies of medical practice must not be allowed to preclude entirely a doctor's participation in both family responsibilities and activities. Certainly, there is a difference between a physician-husband and a husband-physician, and I submit that our proper role lies somewhere between the two extremes. Ideally, a doctor's wife should be viewed as an individual in her own right who complements her husband by serving as his most trusted confidant and advisor and by supervising most of the family's nonmedical affairs. It is of paramount importance that the doctor's wife maintain and demonstrate a sincere interest in her husband's work; moreover, free communication between husband and wife is a sine qua non. Like her husband, the wife of a doctor should continually strive to improve herself in a variety of ways which need not necessarily involve the medical field. Irrespective of a wife's outside activities, it is imperative that her work not interfere with family responsibilities or lead to financial competition with the man of the house. Lastly, I would suggest a policy of setting goals (i.e., something to look forward to) and periodically trying new things since this makes life all the more interesting. *"Whatever you can do, or dream you can do, begin it, boldness has genius, power and magic in it" — Goethe*

In closing, I cannot help but wonder: did my wife surreptitiously and cunningly plan the November Auxiliary meeting primarily for the purpose of educating me? If so, she succeeded!

Reprinted from the Editorial-Letters-Viewpoints section of the Jacksonville Medicine, January 1978. Dr. Nunn is Editor of Jacksonville Medicine.

Sex Education

Lees M. Schadel Jr., M.D.

Today sexual relations in marriage are less concerned with procreation than with providing mutual satisfaction and support within the marital relationship, a change made possible by the development of simple and effective methods of contraception. Confirmation that sex does play a more overt, probably a more crucial, role in marriage is provided by the frank discussion of such matters in modern mass media and a demand for texts providing instruction in sexual techniques and the psychology of sexual adjustment.

There has been a gradual withering away of the double standard of sexual morality, a heightened public concern with rising rates of illegitimacy, abortion, and prenupital conception, and a growing awareness that an older, stricter, more dogmatic code of sexual behavior is no longer appropriate have combined to create a climate of opinion in **favor of sex education**. It is often argued that sex education should be the responsibility of the parents, but this view now receives less support. Illegitimacy and prenupital conception occur most frequently in the lower socioeconomic groups, but recent work has shown that both these pregnancy categories have increased fastest in recent years among women from the upper end of the social-class continuum. Assuming that the existing provision of sex education in the schools has not deteriorated in recent years, then it would seem that the control that even the middle-class parents exercise over their children's sexuality has become less effective.

While the need for **sex education in schools** is generally accepted, considerable confusion still exists concerning what should be taught, who should teach it, in what context, and at what age instruction should commence? Ideally, instruction in human sexual behavior would proceed throughout the educational experience. Children's initial half-formulated questions would be answered fully and frankly but at a level commensurate with the child's level of understanding. As maturation proceeds, the complexity and social context of human sexual response can slowly be revealed. Most certainly a program of sex education would have to deal with the consequences of teenage sexuality. Some teenagers do have sexual intercourse, and, as a result, an increasingly large number of unwanted babies are conceived. A course that sets out to describe the anatomy and physiology of human reproduction, emphasizing the part played by contraception, would provide a basis from which the individual would control his or her future sex life and choose the circumstances under which the responsibilities of parenthood will be accepted.

Female-specific contraceptive techniques as the pill and the diaphragm require the individual to acknowledge that intercourse is likely to occur, but possession of a sheath only requires one to acknowledge that intercourse may occur. Thus, when bargaining proceeds, culminating in sexual exchange the dictates of prophylaxis and prevention of conception can be observed, however unanticipated the encounter, as long as the male partner is carrying a sheath.

Finally one must pose the question: are parental attitudes and public opinion sufficiently "advanced" to accept the principles underlying the course as outlined? Data from interviews with parents (part of a larger study of mass-media influences) focusing on attitudes toward sex education in schools and on what should be included are still being analyzed, but some general impressions have already emerged. It appears that a majority of the mothers interviewed favored the inclusion of topics such as "pregnancy before marriage," "marriage and the family," "biological and physical aspects of sex," "sexual morality," and "birth control and family planning" in a course of sex education for children.

Reprinted from The Record, Official Bulletin of the Broward County Medical Association, August 1977. Dr. Schadel is Editor of The Record.

Marriage is the alliance of two people, one of whom never remembers birthdays and the other never forgets them.

—Ogden Nash

Wake Up, Doc!

Douglass M. Richard*

As a life-long practicing bureaucrat (GP, that is, not a specialist), I have available to me all the statistics one would need to fill up not just this one article but rather this entire issue. The things I could "prove" by use of these stats run the gamut from A to Z, and also from Z to A.

I could "prove" for example, that physicians are the cause of the horrendous annual increases in health care costs. I could also "prove" that physicians play no role whatsoever in these increases. I could "prove" that Medicare and Medicaid have been the primary contributors to the increases in health care costs over the past ten years. I could also "prove" they had a relatively insignificant part to play in that escalation. I could "prove" the whole country's going under if we don't get ourselves a national health insurance program, and soon. And, yes, I could also "prove" NHI's the last thing we need and would, in fact, have us bordering on the brink of bankruptcy very soon after it took effect.

In other words, I could "prove" just about anything I wanted to by strewing around *selected* statistics which, in and of themselves, would actually *prove* nothing. What's really frightening about all this is that it happens all the time. And you and I latch on to those statistics that appeal to us without really looking behind them, without really being informed, without really recognizing that in and of themselves they prove little or nothing. So I'm going to indulge in a little editorial freedom here and, in the body of this presentation, use statistics sparingly if at all.

What, then, does a bureaucrat write about if he can't spew out ominous statistics. Well, he can always prognosticate the future. That's pretty safe, because by the time the prognosticated events come (or do not come) to pass, few readers will remember what he said and practically none of those who remember will care. One in my position can't very well deal in "policy." I'm an administrative officer, not a policy officer. And I've said more than once (three times, in fact!) that in the government an administrative officer is to policy as a eunuch is to sex. (And that, I submit, ought to clarify that little detail!)

*Regional Medicare Director, Bureau of Health Insurance, Health Care Financing Administration, U.S. Department of HEW, 50 7th St., NE, Atlanta, Ga. 30323.

No, no stats, no policy. Just some thoughts developed over the past 4,213 days I've been involved (at this writing) in the Medicare program. None of that which follows is very profound, little of it is new, and much of it might not "set" very well, as we used to say down home in Savannah. But as Regional Medicare Director for the Southeast for 11 years, I've had an unusual vantage point from which to view the passing scene. A vantage point, you say, that would tend to give one a distorted or biased view of things? Perhaps. But consider as well my credentials as a "consumer" of health care (a rather tortured bit of terminology, yet I know of no better way to put it). Given the fact I've a wife who's had two heart attacks in the last ten years plus other assorted ills, such as hypoglycemia, 11 hospitalizations in such diverse places as Atlanta and Johns Hopkins in Baltimore, with the accompanying expenses of insurance, costs above insurance, drug bills equaling if not exceeding physicians' costs — given all that, plus my own past middle-age physiological creakings, groanings, and deterioration, you surely would agree the view isn't really all that slanted.

Speaking to the Florida Society of Internal Medicine during its annual meeting, I expressed one thought that quickly captured the wandering attention of that august group. I said to them (and I say it now to you, because I remain convinced of it to this day) that after working and being subject to the ministrations of physicians over the years, I really believe the average practicing physician doesn't know what the hell is happening to him. I further said that if he doesn't begin to learn what's happening, if he doesn't begin to become involved in *causing* things to happen, he's going to look around one bright and shiny day and discover — to his great surprise and utter horror — that the practice of medicine is no longer what it was (and what he wanted it always to be).

Oh, I'm not talking to those of you who are really involved in organized medicine, who are society officers, convention delegates, etc. I'm talking about the fellow who won't read his *Journal* because he's too busy, about the fellow who won't go to association or society meetings because they conflict in terms of time with hospital rounds, about the fellow who doesn't know (and one wonders whether he would care if he did know) that there are hundreds upon hundreds of bills affecting his vocation and the way he practices that vocation

submitted to the Congress each year. I repeat: I'm thoroughly convinced that poor guy doesn't know what the hell is happening to him. And that's sad. It's sad, too, that I read these journals much more thoroughly than do most physicians. It's sad, too, that in one city where there are about 3,700 physicians, the Medical Association can't muster a quorum at meeting after meeting. No, the poor guy doesn't know what's happening.

What has all this to do with the broad subject of health costs or health financing, to which I understand this issue of MAG's *Journal* is devoted? A great deal, I submit.

Where there is a void, it will be filled. And in the absence of action by the private sector, it will be filled by the government. There was a void, and we got Social Security. There was a void, and we got Medicare. There were voids, and we got Professional Standards Review Organizations, Health Systems Agencies, Program Review Teams, and a myriad of other governmental agencies and actions bearing on the health scene, on health care costs, among other things.

I'm not suggesting these things are bad, mind you. By the same token, I'm not suggesting they're good. I'm an administrative officer — remember the eunuch? What I *am* suggesting, though, is that each of these actions by the government would have been far better both conceptually and in terms of implementation, had there been involvement to a much greater degree of practicing physicians — the people who really know with a real degree of certainty what it takes to render good health care and, conversely, what it *doesn't* take to do so. Had there been greater broad-scale involvement of practicing physicians in peer medical utilization (not fee) review, PSRO probably wouldn't ever have come ambling down the legislative pike. (And don't think you're going to "escape" PSRO just because you're in Georgia. It's coming. Inevitably, inexorably it's coming, either under the aegis of organized medicine or under some other sponsorship.) Health Systems Agencies would still be a figment of someone's imagination had there been forceful, meaningful involvement of practicing physicians in local and area health planning.

And that all leads to another thought. If we really want to do something about health costs, we need to face up to a few things. Despite the pummeling physicians have received in recent years about costs, it's a fact that hospital costs in this country are approximately twice as large as physician costs. I don't know what percentage of hospital costs go for personnel, but it's large, and it'll get larger. And there's nothing much we can hope to do about that. (As the husband of a registered nurse who served in hospitals for years, I've never really understood the logic that apparently assumes hospital personnel can buy groceries at the A&P on their good looks and therefore don't need wages equivalent to those of people in other professions.)

No, we can't do much about that, but something can and *must* be done about the *proliferation* of highly technical, extremely sophisticated, horribly expensive new equipment. CAT scanners come to mind. At $450,000 to $700,000 per scanner — those are very round figures — how much does a hospital add to each patient's cost per day when it purchases one? Easy now — I'm not suggesting that CAT scanners aren't just great, even though there still seems to be some division of opinion in the medical community about that. I'm simply suggesting that heavy physician involvement in the determination of *need* (as compared to prestigious desirability) of such items in a *given* hospital is badly, badly needed. You wonder if physicians can do anything about this? One small example: When an established, recognized and effective planning agency refuses, in effect, to permit hospital "X" to purchase a CAT scanner as unneeded, is the medical community serving the total community when physicians then band together to purchase one and set it up in the professional building next door to the hospital? I think not. Whatever became of peer pressure?

One could go on, but space doesn't permit. To sum up, it's my firm belief that because the average practicing physician doesn't know what the hell is happening to him, he isn't involved, he isn't influential, and he doesn't play the role he should and must in the overall health activities of this country. And because he doesn't, because he sits figuratively contemplating his navel while the whole scene changes around him, everything and everybody suffers, costs continue to shoot up, and the government of necessity continues to fill the void. And that's sad, because it doesn't have to be that way.

One final thought: I believe we've made it to this point without the use of statistical charts and columns of figures. Any time a bureaucrat can do that, there must be some hope for us left!

Reprinted from the Journal of the Medical Association of Georgia, May 1977.

Aspiring people are inspiring people.

Fact Finding Expedition

The Editor:

At the onset, I wish to thank the Duval County Medical Society for the opportunity to write of my experience with two of Jacksonville's hospitals while conducting my "fact finding expedition" on medical malpractice.

As Vice-Chairman of the House Commerce Committee, I have been deeply involved in medical malpractice legislation in the past, and I am sure that I will be dealing with this subject during future legislative sessions. This was the major reason for "working" at these hospitals.

For six Friday evenings, I became a member of the Emergency Room staff at St. Luke's Hospital, and for one day, at University Hospital. I am a firm believer in going out among those people most directly affected by a specific problem, finding out their feelings on different situations, while at the same time, trying to personally experience some of the areas of concern to my constituents. I did this in order to experience the pressure placed upon the doctors as well as the nurses and other hospital staff, and also, to get feedback from the patients they serve.

This is not the first time I've gone "out into the real world" to learn the concerns of my constituents or even to gather information on legislation coming before the Committee. During my tenure as a member of the Select Committee on Farm Labor Relations, I donned my blue jeans and journeyed down to South Florida and joined the ranks of the migrant fruit pickers. I was able to share some of the hardships that plagued these workers. Likewise, I wanted to give myself the chance to experience the decisions of a physician and of the apprehensions and misgivings of the patients.

Bear in mind that I had no previous personal experience with hospitals beyond visiting friends who were confined there. As a Legislator, I feel there is a compelling need to become personally involved in complex areas in order to make the best decisions for all concerned.

I was allowed to sit in on major and minor surgery, and saw many situations in which doctors had to make split second life-or-death decisions. There were auto accident victims, cardiac patients, pregnancies, and your run-of-the-mill cuts, scrapes and bruises. I was impressed with the professional attitude displayed by the hospital staffs and the feeling of concern that they transmitted.

I spoke with many patients and was pleasantly surprised by their sense of receiving good and competent treatment. I did not receive any negative feedback as to care given by, or confidence in the physicians and staff. The majority of the patients had no idea I was a State Legislator, as a matter of fact, most of them thought I was a member of the hospital staff. It was a tremendous ego boost to hear the patients calling me "Doc," and asking what to do for treatment, however, I never gave out any "free" advice.

I wish to thank Doctors S. J. Alford, Samuel Beal, Thomas Meldrum, Thomas Rich, and Robert Cunningham, Hospital Administrator, and the staff of St. Luke's Hospital, and Dr. Cleve Trimble, Chairman, Department of Emergency Medicine and Eileen Wildburger, Supervisor of the Emergency Room, and the staff of University Hospital for their valued assistance in making my observation period so informative and successful.

I invite your input, views and opinions as to legislation which affects your profession. Be assured that my door is always open to you and I look forward to your comments.

Sincerely,

John W. Lewis, III
Representative, 18th District
Florida House of Representatives

Reprinted from the Editorials-Letters-Viewpoints section of Jacksonville Medicine, March 1978.

You are as young as your faith, as old as your doubt; as young as your confidence, as old as your fear; as young as your hope, as old as your despair. In the central place of every heart there is a recording chamber; so long as it receives messages of beauty, hope, cheer and courage, so long are we young. When the wires are all down and your heart is covered with the snows of pessimism and the ice of cynicism, then and then only are you grown old.

General Douglas MacArthur

I Am A Patient

You've seen me a hundred times . . . with many faces . . . many forms . . . many reasons for being in your care.

I am the frightened, middle-aged woman waiting at your admitting desk, nervously opening and closing my purse.

I am the shuffling, stoop-shouldered figure in faded flannel you encounter at every corner as you go about your daily work.

Everything is new and strange to me. Yesterday I was in familiar surroundings and happy, planning my tomorrows. Today I am in an alien world, trying hard to adjust. The little familiar things of my own world seem to take on great importance. I may complain to you. I may rebel against the strangeness. You see, I don't want to be in the hospital, I want to go home.

From the moment I walk up to your admitting desk, I am a mass of fears, I am fearful of the unknown. I am alarmed over the prospect of pain, disfigurement . . . even death. I fear financial distress or catastrophe. More than anything else, I am lonely.

If I tell you my coffee is cold, it may be because coffee is more than a breakfast drink to me. It has a deep symbolic meaning. Through years of experience, I have come to associate it with congeniality, friendship, the warmth and security of home. And just as hot coffee symbolizes these good things to me, cold coffee reminds me that I am among strangers, antiseptic and somehow frightening strangers.

When I object to early morning awakening, I often mean that I am insecure. When I report that my nurse is indifferent, I often mean I feel forsaken.

Please understand that often in my complaints about little things, I am trying to tell you of far deeper needs. Will I lose my identity? Will I be exposed to all sorts of indignities? I'm afraid that I'll be treated, not as a housewife . . . but as a fascinating gall bladder . . . an interesting thyroid. I appear normal, but I have left normalcy outside your door. Though I am mature, I have suddenly become a child, frightened of the long, dark nights. And . . . oh, how I want you to be warm and friendly! I want you to know that I bring with me a personality, not just another problem in surgery or internal medicine. I want you to know I am much more than a name typed on the band welded around my wrist.

I am suddenly hypersensitive. In spite of all your modern equipment, your electric call boards, your walnut admitting counters, I can be devastated by a blunt word from the admitting clerk. It may be that my sensitivity is exaggerated, but when I show the admitting clerk my hospital insurance identification card, make me feel welcome. Let me know you're glad I've come to your hospital. Tell me by your attitude that you respect me as an individual.

You may tell me that what I expect is impossible, that some "discomforts," some "fears" are part of any hospital stay. I will tell you that I understand this perfectly when I am not a patient, but from the minute I enter your hospital, my outlook changes. Minor things take on abnormal importance.

Much of my fright as a fledgling patient comes from lack of understanding on my part. All too often you take for granted that I know these things and I'm left to grope for my answers alone. How can you help me through this twilight period?

Help me bridge my initial feelings of embarrassment. Assure me that the bed-pan is only temporary and that as I improve I'll be able to look after myself to a greater degree. Assure me that I am never alone or abandoned, even on the busiest hospital day. Reassure me that my struggle is not a private one . . . that my feelings, frustrations, resentments and emotions are simply a part of being a patient.

Never forget, you've been a symbol to people like me ever since the Samaritan traveled the road between Jerusalem and Jericho two thousand years ago. The equipment and the methods have changed. But the concept continues unchanged. You're the benevolent healer. You cannot . . you dare not . . change!

Reprinted from the Miami Mercy Hospital publication "Around Mercy" in the section entitled Capsule Comment, March 1978.

The older we get the more we realize that service to others is the only way to stay happy. If we do nothing to benefit others we will do nothing to benefit ourselves.

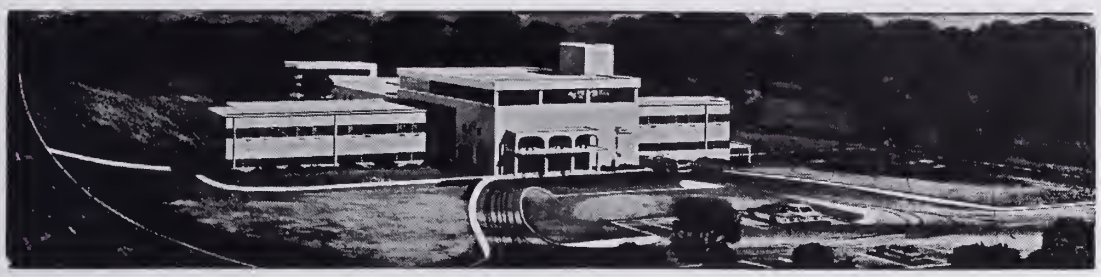
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MEETINGS

Approved by the FMA Committee on Continuing Medical Education

JUNE

Review Course for Certification in Internal Medicine, June, Miami.*

Fifth Annual Florida Perinatal Conference, June 2-3, Dutch Inn, Lake Buena Vista. For information: Donald V. Eitzman, Dept. of Ped., University of Florida, Gainesville 32610.

Nutrition and Management Update, June 7-9, Holiday Inn, Tampa. For information: Ms. Donna O'Steen, 5232 Picador Court, #10, Tampa 33617.

Exercise: Its Effect on the Human Body, June 8, Florida State University, Tallahassee. For information: Philip C. Rond, M.D., Univ. Health Center, Florida State University, Tallahassee 32306.

The Private Practice of Psychiatry, June 8, Mercy Hospital, Miami. For information: Bernard Tumarkin, M.D., 3663 South Miami Ave., Miami 33133.

Bascom Palmer Eye Institute Alumni Meeting and Seminar, June 9-11, Miami.*

Cardiology Weekend: Current Approaches to Clinical Problems in Cardiology in Our Community, June 9-11, Sonesta Beach Hotel, Key Biscayne.*

A Day of Hypertension in Spanish, June 10, Hotel Omni International, Miami.*

Florida Suncoast Pediatric Conference, June 12-14, Sheraton Sand Key, Clearwater.+

Coronary Disease, Exercise Testing and Cardiac Rehabilitation, June 23-25. For information: IMEC, 64 Inverness Drive East, Englewood, Colorado 80110.

Fifth Annual Postgraduate Seminar in Respiratory Care, June 23-25, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Seminar for Intensive and Critical Care Personnel, June 23-25, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Laparoscopy Course, June 26-27, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Advances in Perinatal Medicine, June 30 - July 2, Disney World, Orlando. For information: William N. Spellacy, M.D., Dept. of Ob/Gyn, University of Florida, Gainesville 32610.

JULY

Examination of the Arterial System, July 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.

Clinical Family Planning for Physicians, July 17-18, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Laparoscopy Course, July 24-25, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Computerized Tomography and Patient Management, July 30 - August 2, Hyatt House, Orlando. For information: Lawrence R. Muroff, M.D., P.O. Box 17241, Tampa 33682.

AUGUST

Diagnostic Imaging of the Heart, Aug. 2-6, Hyatt House, Orlando. For information: Lawrence R. Muroff, M.D., P.O. Box 17241, Tampa 33682.

Clinical Electrocardiography and Arrythmia Management, Aug. 11-13, Hyatt House, Orlando. For information: William E. James, Ph.D., 64 Inverness Drive, Englewood, Colorado 80110.

Initial Management of the Pediatric Emergency, Aug. 23-27, Playboy Resort Hotel, Lake Geneva, Wisconsin. For information: Emergency Medical Services Symposia, Inc., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

Laparoscopy Course, Aug. 28-29, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

SEPTEMBER

Transient Ischemic Attacks: The Computerized EEG, September 11, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.

Fifth Annual Cardiovascular Symposium, Sept. 14-15, Hilton Inn, Gainesville. For information: Howard W. Ramsey, M.D., P. O. Box 13494, Gainesville 32604.

Anesthesiology Review and Update, Sept. 15-17, Sonesta Beach Hotel, Key Biscayne. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Sexual Medicine, Sept. 18, Sheraton Riverhouse Hotel, Miami. For information: Domeena C. Renshaw, M.D., 2160 South 1st Ave., Maywood, Illinois 60153.

Clinical Family Planning for Physicians, Sept. 18-19, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Laparoscopy Course, Sept. 25-26, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

OCTOBER

Current Concepts in Neurology, Oct. 12-14, Doral Country Club, Miami. For information: Allan Herskowitz, M.D., 155 Northwest 167th St., North Miami Beach 33169.

Laparoscopy Course, Oct. 25-26, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

***For information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

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FAMILY PRACTICE — Excellent opportunity for physician to perform general practice in expanding North Florida community. Attractive 128-bed new hospital that provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

GENERAL PRACTITIONER: For well equipped medical clinic immediately adjacent to 120 bed skilled nursing facility; would also act as medical director for nursing home. Salary 100% of intake. Contact: Administrator, Wakulla Manor Nursing Home, P.O. Box 508, Crawfordville, Florida 32327. Phone: (904) 926-7181.

FAMILY PRACTITIONER OR INTERNIST WANTED to share facilities with four practitioners in solo practice. Major equipment provided. Rent $250 per month. Competent laboratory and x-ray with income based on use. Bookkeeping system and receptionist shared. Financial assistance available to right party. Contact: T. C. Kenaston Jr., M.D., Box 550, Cocoa, Florida 32922.

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FAMILY PRACTITIONER/INTERNIST, board eligible or certified with some subspecialties. Excellent opportunity for private practice in West Broward, fastest growth area. Modern JCAH accredited 301-bed hospital. Office space available. Financial security. Hollywood/Ft. Lauderdale. Pembroke Pines General Hospital, 2301 University Drive, Pembroke Pines, Florida. Rubin Piha, Administrator. Phone: (305) 962-9650.

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CARDIOLOGIST, FAMILY PRACTITIONER. Immediate openings. Private solo practices, except FP could be partnership. Financial assistance including first year rent free in professional building adjacent to hospital. Contact Claude Weeks, Executive Director, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

SEMI-RETIRED CERTIFIED INTERNIST SEEKING WELL QUALIFIED INTERNIST to share fully equipped office in Palm Beach, Florida. All services furnished. No investment required. Send curriculum vitae to C-842, P.O. Box 2411, Jacksonville, Florida 32203.

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MIAMI FLORIDA AREA. Multispecialty group seeking Internist and General Practitioner. Write or call collect, J. E. White, Medical Director, 1025 E. 25th St., Hialeah, Florida 33013. Phone: (305) 696-0842.

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GROUP OF TWO BOARD CERTIFIED INTERNISTS actively seeking third associate in busy clinical practice. Internal medicine with or without subspecialty training — Southeast Florida Coast. Contact: Yale Citrin, M.D. or Peter S. Irving, M.D., 3435 Johnson St., Hollywood, Florida 33021.

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experience; or graduation from an approved school of medicine or osteopathy and two years of progressively responsible administrative experience in public health or the armed forces; or certification by the American Board of Preventive Medicine. Necessary Special Requirement: License to practice medicine in the State of Florida. Salary range: $30,464 - $41,280 plus fringe benefits. Please send resume to Mr. Max Rothman, District XI Administrator, Florida Department of Health and Rehabilitative Services, Gables One Tower, 1320 S. Dixie Highway, Coral Gables, Florida 33146. An equal opportunity employer.

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30 YEAR OLD FMG WITH FLEX-ECFMG and Florida license, board eligible, general surgery. Presently doing one year of peripheral vascular surgery. Desires solo, partnership or group. Will consider all locations in Florida. Contact: Antonio Vasquez, M.D., 2799 W. Grand Blvd., Detroit, Michigan 48202.

THORACIC CARDIOVASCULAR GENERAL SURGEON, now Clinical Professor of Surgery, wishes to transfer practice to Florida. Association or group desired. Hospital full time also considered. Write C-835, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL AND VASCULAR SURGEON, 35, university trained, board certified, Florida licensed. Seeks practice opportunity, solo, partnership or group. Available 3 months notice. Write C-837, Box 2411, Jacksonville, Florida 32203.

POSITION WANTED: 35 years old, board certified general surgeon, wishes to relocate in Florida. Group, hospital based or partnership. Contact: Jorge A. Melandez, M.D., F.A.C.S., One Hillside Drive, Batavia, N.Y. 14020. Phone: (716) 343-5563.

CARDIOLOGIST, board certified, 35, skilled invasive, and noninvasive techniques, Florida licensed, desires relocation. Write C-861, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST, 30, ABIM eligible, seeks groups, partnership or hospital based practice in Florida. Available July 1978. Reply to C-852, P.O. Box 2411, Jacksonville, Florida 32203.

CLINIC MANAGER — Age 40, currently employed, associated with medical groups that have grown from 8 to 27 in number. Experienced in all areas. Excellent ten-year growth record. For detailed resume write S. Schutte, 130 Lake Sears Dr., Winter Haven, Florida 33880 or call 1-(813)-293-3369.

GENERAL SURGEON, FACS, 43, married, wishes to relocate Naples or Ft. Myers area preferred. Solo or partnership, prefer sharing with another missionary minded physician. Experienced in GYN surgery, Fibroptics of Colonoscopy, Gastroscopy, Bronchoscopy. Write C-869, P. O. Box 2411, Jacksonville, Florida 32203.

PHYSICIAN'S ASSISTANT: Board certified, Ohio license, Florida eligible, employed primary care, also administrative experience, married with children. Desire relocation with solo or group. Contact: C-872, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN — Board certified, eight years experience, bilingual. Seeks position in suburb practice. Reply to: Olga Quintana Sheehy, M.D., 428 Henry St., Fairview, New Jersey 07022.

PRIMARY CARE PHYSICIAN'S ASSISTANT looking for employment with family, group, or hospital practice. May be anywhere in Florida. AMA approved, AAPA fellow. Available immediately. Curriculum Vitae upon request. Mark F. Davy, Box 76-A Poplar Street, Jellico, Tenn. 37762. Phone: (615) 424-7835 collect.

UROLOGIST, FMG, Board certified, university trained, FLEX, seeks solo or group practice. Available July 1978. Write C-870, P.O. Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST-CERTIFIED CP/AP, Florida licensed, native U.S., excellent C.V. and experience as director. Current postgraduate training and certification through 1980. Write: P.O. Box 11185, U.S. Post Office, 227 E. Ontario St., Chicago, Illinois 60611.

INTERNIST/ENDOCRINOLOGIST, 32, ABIM certified, Florida license. Seeks group, solo, partnership or hospital-based practice in Florida. Available July 1978. Write C-873, P.O. Box 2411, Jacksonville, Florida 32203.

OBSTETRICIAN-GYNECOLOGIST: Board eligible, university-affiliated trained hospital, P.G.7, internship, four years program in OB/GYN and two years fellowship in subspecialty. FLEX and Florida license. Seeking for position, medical group membership, partnership. Associate. Location, medium/large community. Available July 1978. Contact: Antonio Reyes, M.D., 59-10 154th Place, Flushing, New York 11355. Phone: (212) 961-7493.

UROLOGY RESIDENT, 33, married, American graduate, military completed, trained at large southeastern university, available October 1978, seeks opportunity in Florida. Write Robert Karp, M.D., 3021 Panaridge Circle, Birmingham, Alabama 35216 or call (205) 934-3411 #401.

PHYSICIAN'S ASSISTANT DESIRES EMPLOYMENT WITH PEDIATRIC emphasis. Other options welcome. Graduating from University of Florida/Santa Fe Program on July 22. Currently a Registered Medical Technologist. Write: Jerry Janiec, B.S., 440 S.W. 20th Ave., Lot #219, Gainesville, Florida 32608.

BOARDED FAMILY PRACTITIONER: Seeks very active general practice. Will cover every third weekend. Please write C-844, P.O. Box 2411, Jacksonville, Florida 32203.

CHIEF RESIDENT IN OBSTETRICS AND GYNECOLOGY, trained by James L. Breen, M.D., seeks partnership or association. Comes highly recommended, available July 1978. Write Ted Cohen, M.D., 127 Old Short Hills Road, West Orange, New Jersey 07052.

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GENERAL PRACTICE FOR SALE: Located in fast growing area in Tampa. Fully equipped. Will introduce. Reason for leaving: going into residency training. For further information write to: John A. Johnson, M.D., 13857 Oak Forest Blvd., North, Seminole, Florida 33542. Phone: (813) 393-9367 (nights).

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FLORIDA INTERNAL MEDICINE PRACTICE WITH OFFICE BUILDING for sale for price of building and equipment alone. Practice, suitable for internist or G.P., is located in rapidly growing retirement community of 8,000 on Central Florida West Coast. Write or call: Kenneth C. Chessick, M.D., 2 West Lemon St., Beverly Hills, Florida 32661. Phone: (904) 726-9180.

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LAKELAND, FLORIDA: FOR SALE 6% down. Air conditioned office for one to three physicians. Main Street, 168 x 140 ft.; double parking lots; extra cottage. Dr. L. Polskin, Box 15966, Honolulu, Hawaii 96815.

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FOR SALE — HIGHLANDS, NORTH CAROLINA. Completely furnished winterized three bedroom, two bath home — 1½ acres — trout pond — wood fireplace and deck. Spectacular view. Harry Long Realty, P. O. Box 156, Highlands, North Carolina 28741. Phone (704) 526-2453.

FLORIDA — SARASOTA. NEW MEDICAL ARTS BUILDING space for lease. Busy Bee Ridge - Beneva area. Will furnish to your specifications. Completion March 1, 1978. Write for details. Allan M. Douglass, Heritage Company of Florida, 1859 Main St., Sarasota, Florida 33577.

FORT LAUDERDALE, FLORIDA. Ideal locations for General Practitioner, Internist, Pediatrician, or Gynecologist. Liberal terms, reasonable rentals. Two of the finest locations in Lauderdale Lakes. Call or write for information to: Lynn Anderson, P.O. Box 9587, Fort Lauderdale, Florida 33310, (305) 484-2400.

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ORLANDO, FLORIDA, FOR LEASE. Medical office, approximately 1,000 sq. ft. located at 6001 Silver Star Road near Mercy Hospital for immediate occupancy. Phone: (305) 295-4644.

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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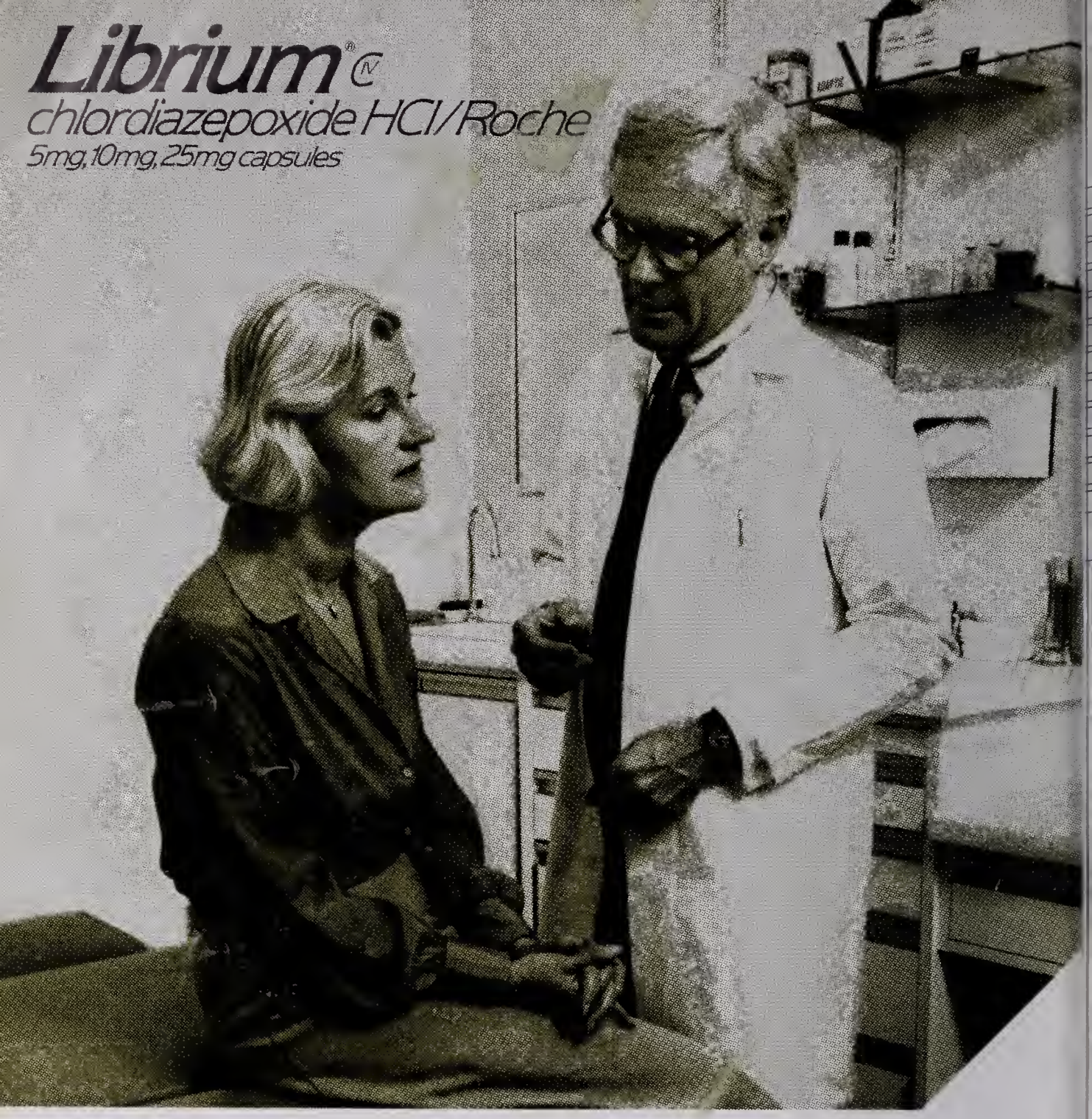
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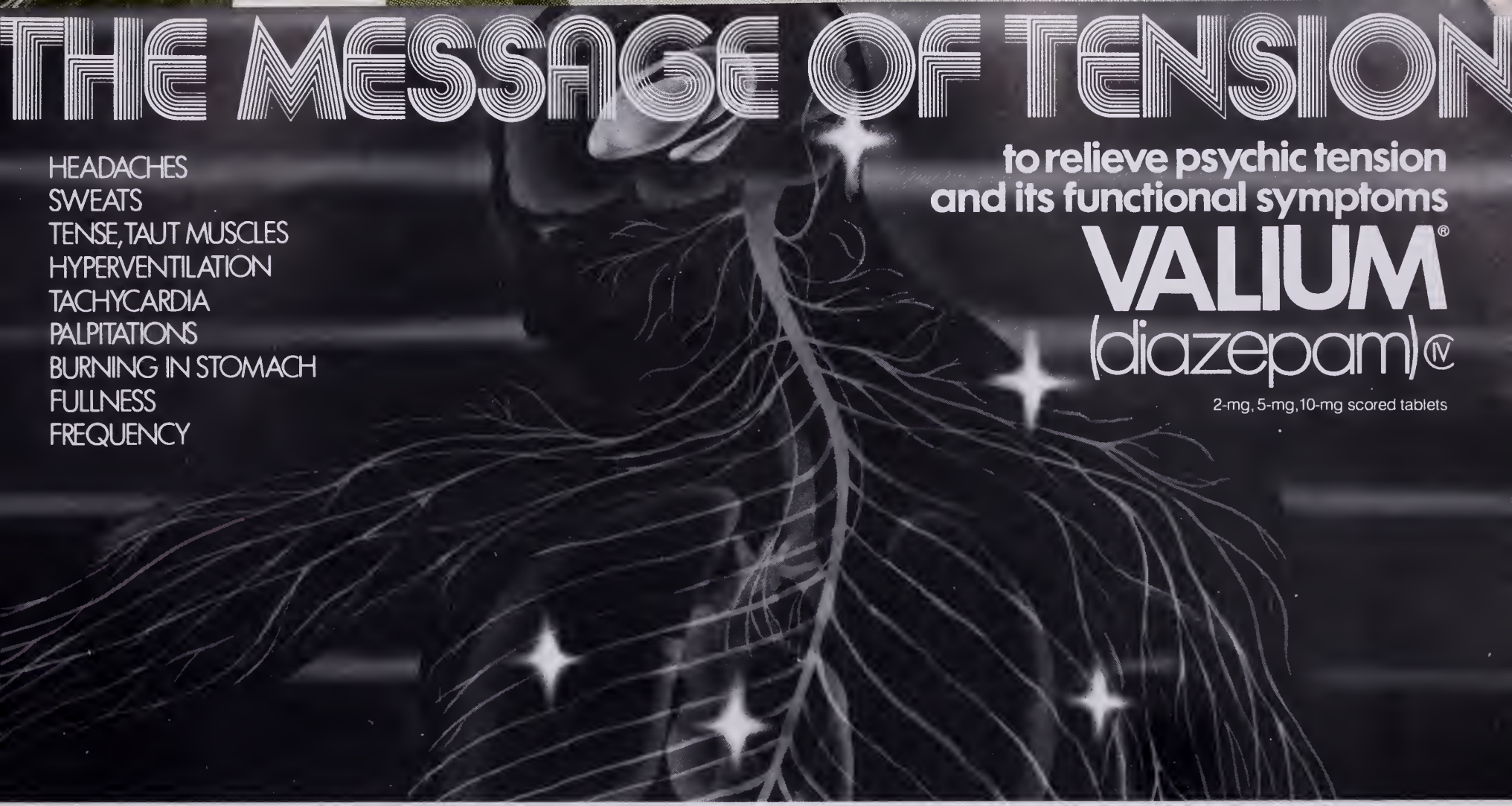
THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION INC

JUNE 1978 • VOL 65 • NO 6

COLLEGE OF PHYSICIANS OF PHILADELPHIA
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Before prescribing, please consult complete product information, a summary of which follows:
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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Our new Medical Necessity Program has two worthy goals:

(1) To help contain costs.
(2) To upgrade medical care.

This program initially identifies 28 surgical and diagnostic procedures which will not be paid routinely by Blue Shield. All pertinent claims will be reviewed for medical necessity and covered only when a clear need can be proven.

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6. Nephropexy
7. Circumcision, Female
8. Hysterotomy
9. Supracervical Hysterectomy
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11. Uterine Suspension with Presacral Sympathectomy
12. Hypogastric or Presacral Neurectomy
13. Fascia Lata by Stripper — when used to treat lower back pain
14. Fascia Lata by Incision — when used to treat lower back pain
15. Ligation of Femoral Vein, Unilateral and Bilateral — when used to treat Post Phlebitic Syndrome
16. Excision of Carotid Body Tumor — when used to treat Asthma
17. Sympathectomy, Thoracolumbar, Unilateral or Bilateral — when used to treat Hypertension
18. Sympathectomy, Lumbar — when used to treat Hypertension
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21. Icterus Index
22. Ballistocardiogram — BCG
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JUNE COVER — Oliver William Davenport, M.D., President of the Florida Medical Association, Inc.

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Haemophilus
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Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



one tablet usually brings gentle, overnight relief

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COLUMBUS, OHIO 43215

Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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IN THE ORLANDO AREA, STAPH RESISTANCE HAS NOW REACHED 79%.*

*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

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(cloxacillin sodium)

..."THE PENICILLIN OF TODAY"

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.
- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary for prescribing information.



Dean's Page

Paradox Revisited

William B. Deal, M.D.

In future decades, we the people, must cope with results of current social trends. These trends are: (a) an epidemic of huge budget deficits, (b) high unemployment coupled with inflation, and (c) declining birth rate. Compounding the problem is the stark realization that our fossil fuel supply is being depleted at a historic rate, precipitating spiraling fuel costs.

In the past, with a high birth rate and a low cost energy, the nation has enjoyed an explosive economy. Our free enterprise system has been dependent on growth! Today, the nation's birth rate is down, longevity is increasing, and energy costs are high; resulting in a sluggish growth in the gross national product. An increasing amount of tax dollars are supporting the Social Security System and Welfare Programs. Example: In the last 10 years, the population has increased 9.25% while Social Security expenditures have increased 4517% (unadjusted for inflation). The food stamp recipients have increased 1375%.

Because of the declining birth rate and increasing longevity, the worker to non-worker ratio will be substantially decreased by the end of the century. The pool of workers supporting the non-workers will be reduced, but the costs of supporting the non-worker will increase. Therefore, two options may be exercised: (1) increasing taxation on the worker, and or (2) increasing Federal budget deficits. One or both will alter the nation's quality of life.

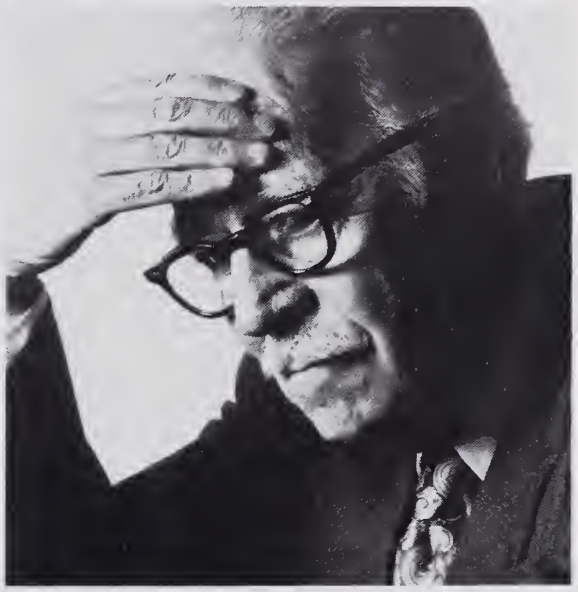
Medicine has been identified by the "policy makers" as a culprit in the inflationary spiral. Massive, voluntary cost containment programs have been instituted nationwide and early indications are that they are effective. On the other hand, the Health Planning Act (PL #93641) which created Health Systems Agencies also required the Agencies to adopt a Health System plan. It is interesting to note what these consumer controlled agencies have planned: increased home health care, increased primary care centers, increased community mental health programs, increased level one and level two skilled nursing beds, and an increase in public health education. As Mr. David Kinzer, President of the Massachusets Hospital Association stated in a recent speech, "The consumers want more not less." More costs more, not less. Can this nation continue to encourage these trends?

Again, another paradox exists. The public must be informed.

Dr. Deal is Vice President for Health Affairs and Dean, University of Florida College of Medicine, Gainesville.

● Dr. Deal, University of Florida College of Medicine, Gainesville 32610.

A TOTALLY NEW DELIVERY SYSTEM TO **HELP REDUCE THE FEAR OF ANGINAL ATTACKS**



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40 mg. capsules ... twice-a-day dosage

Controlled sustained release of ISO-BID's isosorbide dinitrate through micro-dialysis diffusion can help reduce frequency and intensity of anginal attacks. This in turn can minimize patient's fear of attacks, and dependence on nitroglycerin.

Unlike ordinary sustained release products, ISO-BID releases isosorbide dinitrate at a smooth, continuous, predictable, controlled rate to provide for up to 12 hours of therapeutic activity. Micro-dialysis is dependent only upon the presence of fluid in the G.I. tract and not on pH or other variables. ISO-BID is particularly advantageous in the prevention of nocturnal angina.

DOSAGE: One ISO-BID capsule every 12 hours on an empty stomach according to need, for continuous 24-hour therapy. Some patients may require higher dosage levels. In these patients, dosage should be titrated, and they may require two ISO-BID capsules b.i.d. Not intended for sublingual use. Consult product brochure before prescribing.

THERAPEUTIC FOOTNOTE: IN TREATING ANGINA . . . FAILURES MAY RESULT FROM INADEQUATE DOSAGE
Reports in the literature indicate the usefulness of higher dosage levels of isosorbide dinitrate.[1,2]

INDICATIONS: Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

SAMPLES AND LITERATURE AVAILABLE.

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1. Shane, S.J.: Canadian Family Physician, November 1973. 2. Lemberg, L.: Practical Cardiology, February 1976.

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This plan provides valuable protection against the high costs of extended hospitalization. It pays 80% of your covered hospital expenses up to a maximum of $15,000, after your deductible has been satisfied. All FMA members under 60, and eligible family members may apply. All applicants must meet the underwriting requirements of the plan.

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This plan takes over where your regular medical insurance leaves off. It pays 100% of your reasonable medical expenses up to $100,000 per accident or sickness for prolonged hospitalization, after the deductible has been satisfied. Acceptance is guaranteed to all FMA members under age 60 and eligible family members.

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This plan provides up to $5,000 a month to help you meet your overhead office expenses when you are totally disabled due to a covered accident or illness. All FMA members under 60 are eligible to apply and will be issued coverage if they meet the underwriting requirements of the plan.

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1954
1978



BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

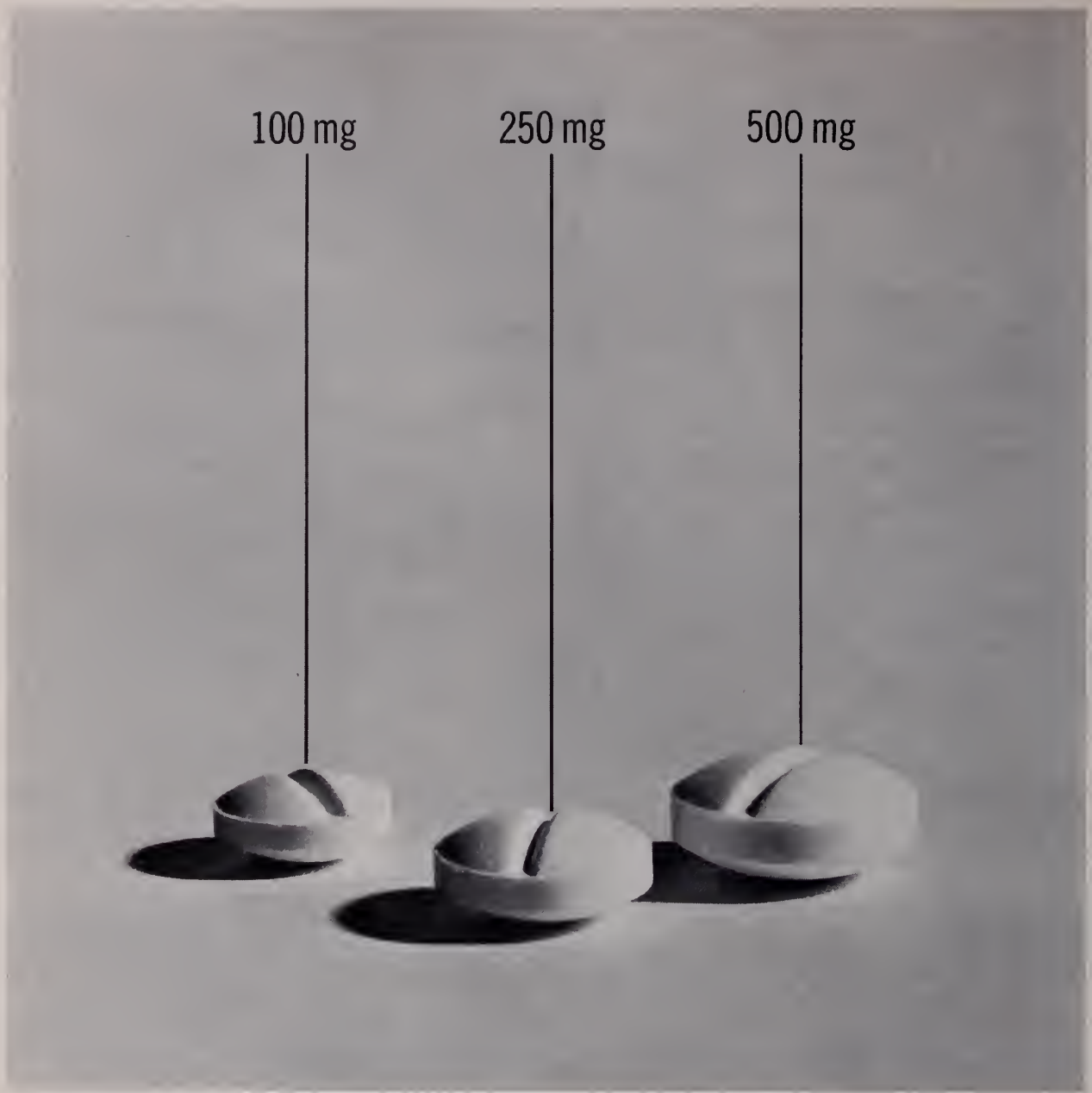
In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

Kaon® Elixir
(potassium gluconate)
20 mEq per 15 ml

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Nature just doesn't make a perfect food.

No one food supplies all the nutrients children need.

But milk supplies more essential nutrients per calorie than most other foods.

A child between the ages of six months and six years, for example, can get at least three-fourths of his daily dietary allowance for calcium, riboflavin, vitamins D and B_{12}, phosphorous, and protein from just three glasses of milk. And milk is also a good source of vitamins A and B_6, as well as thiamin and niacin (please see chart).

That's why the U.S.D.A., acting on the recommendation of the National Research Council—National Academy of Sciences, has established these guidelines for milk consumption:

Children up to 6 years
Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

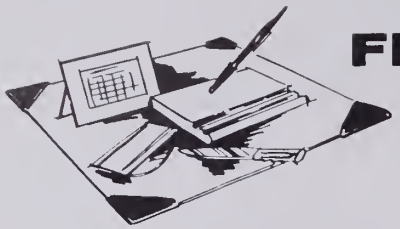
Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on: 60 mg tryptophan=1 mg niacin

ndc **National Dairy Council**

Milk. Sometimes we forget all the good things it does.



FROM THE EDITOR'S DESK

The Florida Medical Association has expressed indignation over President Carter's recent charge that organized medicine is more interested in its members' welfare than it is in patient welfare. A resolution repudiating the President's attack was adopted at the closing session of the FMA House of Delegates in Hollywood on May 7 (see page 457).

The California Medical Association is recalling 27,000 copies of its Relative Value Studies (RVS). The action is being taken under terms of a consent agreement with the Federal Trade Commission which charged the RVS helps doctors fix fees in violation of antitrust laws. A CMA official expressed confidence that the Association could eventually win the case but only after years of litigation and monumental costs. He pointed out that while the FTC insists that the RVS no longer be used by physicians, other government agencies use it to determine health program payment levels.

The staffs of the AMA and Sen. Edward Kennedy are planning a disease prevention conference at Washington's Shoreham Hotel, July 25-27. Details have not been worked out.

The federal government put the final version of its health planning guidelines into effect on March 24. They represent little change from interim guidelines published in January. The guidelines are designed to serve as national standards for local health systems agencies and state health planning agencies.

Although Congress last year rejected the Federal Trade Commission's move to get expanded authority, the FTC has renewed its effort to win jurisdiction over non-profit organizations. FTC Chairman Michael Pertschuk told a congressional subcommittee the agency is intensifying its investigation of the role of physicians on Blue Shield boards of directors. He charged that doctors control nearly all the plans and that this may be creating inflated fees. In reply, national Blue Cross-Blue Shield President Walter J. McNerney said physician membership on the boards is now less than 50%. He predicted the FTC investigation would show that Blue Shield has worked in the public's best interest.

Minneapolis will be the host city for the Third National Conference on Impaired Physicians. Sponsored by the AMA in cooperation with the Minnesota Medical Association, the conference is scheduled for September 29 to October 1. Discussion will center on state medical association rehabilitation programs, legal aspects of impairment, and hospital-developed programs.

That error-riddled list of 1975 Medicare payments continues to embarrass the Department of HEW. The list issued last year was found to be 65% inaccurate. The General Accounting Office says HEW spent $14,000 to prepare the list and $122,000 to correct it. In a related development, GAO sent agents to the Social Security Administration's computer center to test the security there. They walked away with 38 tapes containing information on more than 1 million beneficiaries. "They were kind of embarrassed," GAO said of Social Security.

The AMA Speakers Bureau has organized a national contest for physicians who represent their medical societies in public speaking and legislative testimony. Winners will receive trophies and their medical societies will receive cash awards to assist in further development of their speaker bureaus.

A professionally managed, no-load, diversified open-end mutual fund has been established for AMA members and the public. It's called the American Medical Association Tax-Exempt Income Fund, Inc. The fund's objective is to achieve as high a level of federally tax-exempt income as is consistent with prudent investment and preservation of capital. The portfolio will consist primarily of municipal bonds. Minimum initial investment is $2,000. Investment advisor is Continental Illinois National Bank and Trust Company of Chicago. Distribution is handled by Becker Securities, Inc., of Chicago, except in Virginia, where Davenport and Company of Virginia, Inc., is distributor.

The Resident Physicians Section of the AMA is publishing a workbook on successful cost containment activities in teaching hospitals. It is to be available at the AMA Convention in St. Louis in June. The AMA has endorsed development of programs to increase understanding and awareness of medical school faculty, students and house staff of the cost of health care.

Speakers at a conference in Washington in March agreed that Americans are satisfied with their medical care and may be slow to accept Health Maintenance Organizations (HMOs). Nevertheless, they believe that HMOs eventually will be used by most Americans. The conference, sponsored by the Department of HEW, was attended by about 1,000 persons representing 320 corporations and 350 labor unions. HEW Secretary Joseph Califano said HMOs could reduce outpatient visits by 15% and hospitalization by up to 60%.

The American Bar Association (ABA) has published the proceedings of the National Medicolegal Symposium held last year in San Francisco under the sponsorship of the ABA and the AMA. The book includes discussion of such topics as "Social Impacts of Professional Liability," "Professional Ethics: The View from the Bar," and "How to Protect the Professional from Consumerism." Copies are available at $7 each from AMA, P. O. Box 821, Monroe, Wis. 53566.

The Defense Department has withdrawn its proposal to abolish the job of Assistant Secretary for Health Affairs in the wake of an unfavorable vote in a House Armed Services Subcommittee. Health affairs would have been transferred to the office of Assistant Secretary for Manpower. This move, in the opinion of Subcommittee Chairman Samuel Stratton (D-N.Y.), "could only result in degrading and downgrading this most essential element of fighting readiness for all of our armed forces."

The AMA has urged Congress to extend for one year several federal health programs. These include comprehensive public health services, migrant health services, the National Health Service Corps, immunization and disease control, venereal disease control, and others. AMA urged changes in some of the programs and recommended a program for funding comprehensive hemophilia treatment centers not be extended. Private and public programs are providing quality care for person with hemophilia, the AMA said, and increased support for basic research in this area would be a more productive use of federal funds.

A report on physicians' fees released in March by the White House has been assailed widely in medical quarters. AMA Executive Vice President James H. Sammons, M.D., appearing on the **Today** television show, said the $63,000 median income figure for 1976 cited in the report is based on a magazine's survey of five specialties and has not been confirmed. He said a more elaborate study conducted by AMA shows a median income of $54,000 for all physicians that year.

The House Commerce Subcommittee on Health has made important changes in legislation to extend Certificate of Need to physicians' offices. Certificate of Need would apply to physicians' offices only if the equipment is to be used for institutionalized patients. The Subcommittee also approved changes to require that 50% of the providers on health systems agency governing bodies be direct providers and to make hospital "decertification" programs voluntary. The AMA has urged these changes.

The Editor

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Changing Concepts in Management of Congestive Heart Failure

Louis Lemberg, M.D.

Abstract: The conventional management of congestive heart failure (CHF) has undergone significant changes in recent years. Fixed and long-established therapeutic customs have been subjected to critical reexamination with the result that many have been abandoned in favor of newer observations.

Many recent contributions to cardiac care have been made possible with the advent of coronary care units where continuous monitoring permits detailed clinical studies. The emergence of the vasodilators as effective therapy in CHF is one of the important contributions; another is the sophisticated use of modern diuretics.

As a consequence, the routine practice of using digitalis in all patients with CHF has been challenged. Likewise, the long controversy regarding the role of digitalis in heart failure during the early days of an acute MI appears to be ending with the weight of evidence against its use.

Current concepts in the management of CHF emphasizing the changing role of digitalis are presented in two sections. The first deals with management of CHF as a general topic; the second with left ventricular failure complicating an acute MI.

Definition of Congestive Heart Failure: A Guide to Therapy

Congestive heart failure (CHF) is defined as the inability of the heart to deliver a blood supply adequate for the metabolic requirements or circulatory demands of the body. Using this definition a simple equation can be written:

CONGESTIVE HEART FAILURE
CARDIAC OUTPUT ≠ PERIPHERAL DEMANDS
(does not equate with)

This definition for heart failure is appropriate, providing the venous return to the right heart is normal or above. A low preload may lead to hypovolemic shock. It is not a usual feature of congestive heart failure.

The equation defining heart failure helps to categorize the basic principles of therapy. Treatment is aimed either at improving cardiac output or at lowering the peripheral demands in order to equate the metabolic requirements with a reduced cardiac output. Frequently therapy includes measures directed at both sides of the equation, i.e., increasing cardiac output and reducing cardiac work.

The digitalis glycosides are appropriately placed on the left side of the equation. All other medical therapy for CHF reduces peripheral demands or cardiac work and thus appears on the right. Management to reduce cardiac work can be divided into three basic therapeutic strategies: (1) Rest: physical and mental; (2) Manipulation of the sodium ion, and (3) Reduction of the preload and afterload.

These three compensate the failing heart by equating the peripheral demands of the body with the capacity for cardiac work. In turn, an improvement in cardiac output results, when the workload is reduced.

	Cardiac Output	≠	Peripheral Demands
Management	Digitalis		—Rest: Physical-Mental —Manipulation of sodium ion —Reduction of preload and afterload
	(improves cardiac output)		(reduces cardiac work)

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General Concepts in Management

Digitalis has always been considered the key to compensation when treating CHF. Although the importance of the other therapeutic measures was appreciated, routine digitalization was carried out, nevertheless, in every case. In recent years, however, the management of CHF has taken a new and sophisticated direction. Currently, measures that reduce cardiac work attract more interest than drugs that improve myocardial contractility. Specifically, the focus is on vasodilating or unloading agents which reduce the work of the heart by decreasing cardiac preload and afterload. In the recent literature, selective vasodilation was proven to be the decisive factor in reversing severe CHF, refractory to all other therapy.[1-22] The emergence of the unloading agents as the key to the management of the most difficult problems in heart failure tends to reduce reliance on the digitalis glycosides. In addition, sophistication in the use of modern diuretics has further contributed to the declining role of digitalis.

Four Basic Aspects of Management

Digitalization: A Declining Influence on CHF

Patients with uncomplicated CHF generally respond promptly to a decrease in physical work, reduction in mental stress, diuretics and restricted sodium intake. Diuresis and improvement in symptoms often occur within the first 36 to 48 hours and compensation is frequently achieved long before attaining therapeutic levels with conventional digitalization. The result is that there are no clear clinical signs or symptoms that would identify a correct dosage of digitalis early in the course of treating failure in patients with sinus rhythm; digitalization is then completed in cookbook fashion since clinical guidelines are no longer present. The role of digitalis in achieving compensation would thus appear limited in light of the prompt and earlier improvement in symptoms and signs resulting from diuretics and other measures that reduce cardiac work. Furthermore, compensation can often be maintained using diuretics in place of digitalis.

When CHF complicates an atrial arrhythmia with a rapid ventricular response (atrial fibrillation, atrial flutter) the primary therapeutic drug is digitalis given in loading doses. Here, the aim in therapy is a prompt reduction in the ventricular rate, achieved by the negative dromotropic property of digitalis. The clinical state dictates the method of digitalization.

Reduction of Preload and Afterload

Vasoactive drugs which increase the capacity of the venous bed (preload) and reduce arterial pressure (afterload) have proven to be highly effective in the treatment of CHF. Remarkable results with these agents have been obtained in severe cases of refractory failure. The vasodilators currently used are the nitrites, nitroprusside, hydralazine, phentolamine, trimethaphan, prazosin, and minoxidil. Hemodynamic indices following the use of these vasodilators show a decrease in pulmonary artery and left atrial pressures, an increase in venous capacitance, and a decrease in blood pressure (Table 1). As a result there is an increase in cardiac output and diuresis.

Table 1

Vasodilator	Site of Action	
	Arterial	Venous
Nitroglycerin	+	++
Isosorbide	+	++
Nitroprusside	++	++
Hydralazine	++	+
Phentolamine	++	+
Trimethaphan	++	++
Prazosin	++	++
Minoxidil	++	+

References 1-22

Rest

In principle, this aspect of patient care involves a modification of lifestyle in order to reduce physical activity and the exposure to emotional stress. Toward this end, the periodic and judicious use of tranquilizers and sedatives are often helpful.

Manipulation of the Sodium Ion

Congestive heart failure is accompanied by sodium retention and hypervolemia. When left ventricular failure is precipitated by acute cardiac pathology, hypervolemia is initially confined to the lesser circulation and results from shifts in fluid compartments. In either case, but particularly in the former, removal of fluid helps significantly in reversing the pathophysiology of CHF.

The positive fluid balance in CHF is a renal response due to a poor cardiac output. In managing heart failure the vascular volume is influenced by: (a) sodium intake; (b) natriuresis with diuretic drugs, and (c) fluid intake. When initiating diuretic therapy, the objective is to strike a balance between the salt intake and the strength of a diuretic so that an effective diuresis results. The degree of dietary sodium restriction inversely determines the dose of the diuretic. The effectiveness of diuretics in reversing failure has been confirmed by hemodynamic studies and compensation can often be attained without the use of digitalis and its attendant risks. Finally, in advanced states of CHF, restriction of fluids may be required.

Factors That Complicate CHF

Failure to recognize and deal with those correctable factors that complicate the primary cardiac disease makes compensation difficult if not impossible to achieve.

The circulatory demands made on the heart are influenced by physical and mental work,* and by the physiologic functions of the organ systems. Derangement in any of these influences may gravely increase the cardiac workload and create obstacles in relieving heart failure. Effective management of these derangements reduces peripheral demands on the heart and is frequently the key to successful control of "refractory" CHF.

The recognition and treatment of iatrogenic disorders such as electrolyte imbalance, cardioactive drug overdosage or drug reactions are often paramount in reversing decompensation.

Remedial heart surgery for congenital or acquired structural defects of the heart is always a prime consideration when these defects seriously limit the cardiac output.

Discussion

Extensive experience with diuretics and more currently the dramatic and successful results attained with vasodilating drugs have revolutionized our concepts of management in CHF. With the former, there is a reduction in fluid volume in the vascular bed; with the latter an increase in the size of the vascular bed. The combination of diuretics and unloading agents therefore has additive effects on the reduction of preload and afterload.

Digitalis improves contractility of the myocardium. However, an increase in the force of contraction is not equivalent to improvement in cardiac performance because contractility is only one of four determinants of cardiac output. The other three are preload, afterload and heart rate.

Cardiac compensation can be depicted as a chain having four links where each link represents one of the four determinants of cardiac output. Since a chain is as strong as its weakest link, the role of any determinant of cardiac output can be appreciated with the following illustration. Assume that an abnormal heart rate is the primary factor responsible for heart failure; then merely improving myocardial contractility would not be adequate in achieving compensation because the abnormal heart rate which is the limiting factor (weakest link) had not been corrected.

The increase in contractile force with the use of digitalis can compensate the failing heart only if the three other links in the "chain of compensation" are intact. These three, preload, afterload and heart rate, directly influence the work load of the heart and indirectly improve cardiac output. Appropriate attention to all four determinants of cardiac output is essential in achieving compensation. Frequently, however, management that is primarily directed toward reducing cardiac work is more important than the use of digitalis. In fact, contrary to the classic view, CHF can now be controlled in most cases without digitalis. Modern diuretics and vasodilators can replace digitalis in the majority of cases of CHF. In addition, it is worth noting that a vasodilator was the key to compensation in "refractory" failure in a number of recent reports.

The following conclusions are drawn from the literature and personal observations: (1) Therapeutic measures which reduce cardiac work are frequently the major determinants of cardiac compensation; (2) A diuretic is the first drug to use in mild to moderate CHF; (3) Vasodilators are very useful adjuncts in the treatment of congestive heart failure. When other methods have failed, severe failure can be reversed when these drugs are added; (4) Digitalis is not always the primary treatment for CHF; (5) Many patients with CHF can be managed without digitalis, and (6) a loading dose of digitalis is rarely required.

Left Ventricular Failure Complicating an Acute Myocardial Infarction

Left ventricular failure (LVF) has been known to be a common complication of acute myocardial infarction (MI). Despite the frequent incidence, the method of treating this complication during the early stages of infarction always prompts discussion. Controversy centers on the efficacy of digitalis because its value in failure provoked by an acute MI is yet to be established.

Left Ventricular Failure and Decreased Ventricular Compliance in Acute MI

Signs

Left ventricular failure in acute MI is clinically manifested by moist rales at the lung bases, a left ventricular gallop and chest roentgenographic evidence of pulmonary vascular dilatation, blurring of vascular margins, or parenchymal clouding. The radiological signs can be seen in one third of the subjects with congestive heart failure. A ventricular gallop and moist rales at the bases can be heard in about 50%. However, it is important to emphasize that the clinical recognition of these signs of failure may be an inaccurate guide as to the presence or absence of decompensation. For example,

*Mental work is used here in its broadest implications to include anxiety, worry, tension, emotional stress, etc.

auscultation has to be exceptionally thorough otherwise the true incidence of rales or gallops will be underestimated. A portable chest x-ray of the acute cardiac at the bedside is often difficult, and accurate diagnoses of early failure require precision in technique and interpretation.

Hemodynamic Indices

The true incidence of LVF in acute MI may be difficult to ascertain clinically or hemodynamically for additional reasons. An elevated left ventricular end-diastolic pressure (LVEDP) is the hemodynamic hallmark of LVF. In studies performed in the experimental animal laboratory and subsequently in man, a high LVEDP frequently found during the early days of an acute MI was shown to be due to a decreased compliance of acutely infarcted myocardium rather than LVF: the left ventricular end-diastolic volumes were normal, a finding that rules out LVF.[23]

The elevated LVEDP due to decreased compliance of the infarcted myocardium produces an increase in mean hydrostatic pressure which is transmitted from left ventricle to left atrium and then to the pulmonary veins and capillary bed. A left ventricular gallop and pulmonary congestion usually result. These signs that result from decreased ventricular compliance are the same as those due to LVF. In other words, the classic signs of LVF observed in the wake of an acute MI may be due to decreased left ventricular compliance (muscle stiffness) rather than LVF (muscle weakness) (Fig. 1).

Since in acute infarction it is difficult to clinically distinguish between LVF and decreased left ventricular compliance, the use of digitalis in this setting is open to question and debate. There is nothing to indicate that digitalis can improve the hemodynamic abnormalities due to a decrease in left ventricular compliance. However, the increase in pulmonary vascular fluid volume resulting from a high LVEDP can be lowered by diuretics or vasodilators in either case.

Hemodynamic Response To Digitalis in LVF of Acute MI

In the last decade a number of reports have been published in which the role of digitalis in LVF following an acute MI was evaluated. The results summarized in Table 2 fail to show any significant hemodynamic improvement following the use of digitalis.

In other experiments conducted on canines, the intravenous administration of acetylstrophanthidine one hour after an acute MI complicated by LVF did not produce any hemodynamic benefits. The identical dose given one week later to the same animals with LVF resulted in a positive inotropic effect.[24] In acute MI this response to digitalis may thus depend on the time of administration. The studies would suggest that digitalis may be effective in treating LVF only if given after the fourth or fifth day of an MI.

On the other hand, the efficacy of digitalis in suppressing the ventricular rate whenever atrial tachyarrhythmias complicate and acute MI has been well established and requires no affirmation.

Problems Related to Digitalis in Acute MI

The risks attendant to digitalis are greatly enhanced when it is used in an acute MI. A review of these risks and related problems follows.

Ventricular premature beats are common in acute MI and in digitalis toxicity. The latter occurs with 60% of the therapeutic dose when given in the acute stage of an infarct. As a consequence the frequent concurrence of ectopic beats in this setting makes use of digitalis difficult even with lower dosing schedules.

Intravenous digitalis produces prompt although transient arterial vasoconstriction. Complications have been reported and are probably related to the sudden increase in afterload (Table 3).

A major goal in the management of an acute MI is the preservation of ischemic myocardium. Digitalis increases myocardial oxygen consumption and when given in the absence of LVF promotes extension of the



Fig. 1. — An elevation in left ventricular end diastolic pressure may result from left ventricular failure or diminished left ventricular compliance. The hemodynamic consequences, in either case, are the same, i.e., signs and symptoms of pulmonary congestion. LVEDP = left ventricular end diastolic pressure; LAP = left atrial pressure; PVP = pulmonary venous pressure.

Table 2. — Acute Digitalization in Myocardial Infarction.

Author	Year	Clinical Failure	Cardiac Output	Blood Pressure	LA and PA Pressures
Malmcrona	1966	No LVF	No change	↑	—
Gunnar	1967	↑CVP ↓CVP	↑ No change	↑	—
Balcon	1968	Early LVF	Initial then recovery		No change
Cohn	1969	Shock	No change	↑	↓
Sjogren	1970	LVF	← No change →		
Hodges	1972	Early LVF	← No change →		
Karlinger; Braunwald	1972	LVF	Insufficient experimental and clinical evidence for use of digitalis		
Wolk; Killip	1972	LVF	Hemodynamic benefits, not proven		
Swan	1975	LVF	Advises against use of digitalis for LVF in the first 96 hrs of an MI		

CVP — central venous pressure
LA — left atrium
PA — pulmonary artery

Table 3. — Complications of Intravenous Digitalization in Myocardial Infarction.

Author	Year	Complications	Number Cases
Balcon	1969	Angina	1
Lown	1968	Ventricular failure	2
Cohen	1969	Pulmonary edema	2

zone of necrosis. The same adverse response can be expected with the use of digitalis when the signs characteristic of LVF are a result of decreased left ventricular compliance rather than LVF.

The negative dromotropic* property of digitalis may expose latent A-V block in an acute inferior wall infarction.

The clinical end point of digitalis therapy is difficult to judge when treating LVF during an acute MI because of the unstable functional state of injured myocardium, a factor that influences the severity of the heart failure.

Digitalis may enhance the paradoxical systolic expansion of an infarcted area by increasing contractility in the surrounding uninvolved myocardium.[25] This results in a smaller ejection fraction and a lower cardiac output.

Discussion

In light of all these considerations, when managing LVF complicating an acute MI major reliance should be placed on diuretic and vasodilator therapy. The urine output is a prompt measure of a response and serves as a simple guide to therapy. Symptomatic improvement frequently parallels an adequate diuresis; the resolution of pulmonary rales, however, has a short lag period.

In mild LVF, only diuretics are required. With severe degrees of heart failure major reliance is placed on diuretics and vasodilators. Modest doses of digoxin can be given after the fourth day. The use of diuretics entails little risk as long as there is awareness that hypovolemia and electrolyte imbalance are potential complications. Added benefits to the treatment of LVF are derived from the vasodilating drugs. The nitrites sublingually or in an ointment base are effective examples and simple to use (Tables 4-6).

Table 4. — Principles in the Management of LVF Complicating Acute MI.

First 96 hours

- Major reliance on diuretics and vasodilators
- Digitalis is ineffective in the first 96 hours
- Hemodynamic monitoring may be indicated

Table 5. — Treatment of Mild LVF Complicating Acute MI.

- Restrict sodium to 1 gm/day
- Oral or I.V. diuretics
- Nitroglycerine paste may be used
- Oxygen

Table 6. — Treatment of Severe LVF Complicating Acute MI.

- Restrict sodium to 500 mg/day
- I.V. diuretics
- Vasodilators
- Monitor pulmonary capillary wedge pressures
- Potassium replacement
- Oxygen

When manipulating intravascular fluid volume with diuretics, or the capacity of the vascular bed with

*A term which describes A-V transmission time.

vasodilators, hemodynamic monitoring may be necessary. A left ventricular filling pressure (LVEDP) between 12 and 18 mm Hg is desirable in order to prevent or improve pulmonary congestion without causing a serious decrease in blood pressure.

Summary

The sophisticated use of modern diuretics and the establishment of vasodilators as key agents in reversing "refractory" CHF have all but toppled the digitalis glycosides from their position as being indispensible to the management of CHF.

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Errata

In the March 1978 issue of the Journal, special issue on "Adverse Reactions to Plants in Florida," the following errors were noted:

Page 185 (Illustrations) Top line of illustrations are erroneously labeled and should read as follows, left to right: Chlorophyllum molybdites — Amanita muscaria — Amanita phalloides

Page 185 (Illustrations) First picture of middle row — caption should be: Coprinus atramentarius

Page 187, Column 1, line 5. First word should be coprinus

Page 192. To be added as a footnote to entire article:
"My botanist friends have indicated that the correct botanical name of Angel's Trumpet is Datura candida, not Datura suaveolens, which is the botanical name of another member of the Datura family. I stand corrected." — Author

Page 196, Reference 9 — Dr. Hall's initials should be R.C.W.

Page 202, Column 2, line 20: Botanical name, in parentheses, should be Lepiota morgani

Tumor Associated Hypoglycemia and Elevated Serum Nonsuppressible Insulin-Like Activity

Albert Castro, Ph.D.; Luis Florez, M.D.; John J. Rozanski, M.D., and Daniel H. Mintz, M.D.

Abstract: Markedly elevated serum nonsuppressible insulin-like activity (NSILA-s) as measured by the specific radioreceptor was found in two patients with intractable hypoglycemia and extrapancreatic neoplasms (hepatoma and mesenchymal tumor). Immunoreactive insulin levels were consistently low. NSILA-s levels may prove to be of important diagnostic value in helping to distinguish extrapancreatic neoplasms from insulinoma, especially when glucose-insulin relationships are nondiagnostic. Elevated NSILA-s appears to be specific for such extrapancreatic hypoglycemia producing tumors.

While the pathophysiology of insulin-mediated hypoglycemia in insulinoma has been well established,[1-3] the mechanism of hypoglycemia associated with certain extrapancreatic tumors has been the subject of much controversy in recent years.[4-7] Evidence is accumulating that certain extrapancreatic neoplasms can secrete one or more peptides which have potent physiological insulin-like activity yet are immunochemically distinct from insulin.[8-11] The best characterized substance is serum nonsuppressible insulin-like activity (NSILA-s) which is soluble in acid-ethanol. An immunochemically identical material exists in normal humans and in humans with insulin-induced hypoglycemia.[12] A specific radioreceptor assay for NSILA-s has recently been developed,[13] and elevated levels have been found in a small number of patients all of whom had extrapancreatic tumors and severe hypoglycemia.[4,12]

In the following report two patients with intractable hypoglycemia were found to have extrapancreatic tumors and markedly elevated serum NSILA-s.

Methods

Venous blood was collected with 10 u of heparin per ml of blood. Plasma was immediately separated and divided into two portions, one of which was frozen until insulin assays could be performed while the other was analyzed promptly for glucose with the Beckman analyzer. A plasma glucose pool was incorporated into each experimental run as a check on the variability of the glucose estimation; this pool did not vary by more than 2 mg per 100 ml during the study. Plasma insulin concentrations were assayed by a modification of the Morgan and Lazarow technique.[14] Standard human insulin was kindly provided by Dr. Mary Root of Eli Lilly and Company.

Samples of plasma glucagon were obtained in trasylol (1000 KA units per tube) which were immediately centrifuged and plasma frozen until glucagon assays were performed according to the Unger technique.[15] Glucagon antibody (30k) was kindly donated by Dr. R. Unger of the University of Texas School of Medicine.

Insulin and glucagon were labeled according to Greenwood and Hunter.[16] The purity and specific activity were verified before use in our laboratory by radioactive scanning of paper strips following electrophoresis of samples in veronal buffer and chromatography in an ethanol water system. As a check on the variability of the insulin and glucagon radioimmunoassay, a standard plasma pool sample was assayed with each run of unknown of plasma insulin and glucagon. Consistent values were obtained throughout the study: insulin 53.9 μU/ml, S.D. = $\pm$ 3.5 μU/ml, glucagon 76.0 pg/ml, S.D. = $\pm$ 3.6 pg/ml.

Assay for nonsuppressible insulin-like activity was performed by Dr. Klara Megyesi of the Diabetes Section, Clinical Endocrinology Branch, NIH.

Report of Cases

Case 1. A 33-year-old black female was brought to the hospital in a comatose state. Shortly after admission serum glucose of 10 mg% was found. For three weeks prior to admission she had experienced light-headedness before meals. Three days prior to admission she was given propoxyphene and sulfisoxazole for a urinary tract infection. At 8:30 a.m. of the day of admission she awoke with diaphoresis and light-headedness and soon after lapsed into coma.

On examination the patient appeared thin and wasted with a protuberant abdomen. Blood pressure was 150/99 mm Hg, pulse 80/min and regular, and

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temperature 37 C. The liver was firm and nodular with a total span of 20 cm in the midclavicular line.

Initial laboratory data revealed sodium 147 mEq/L, potassium 4.3 mEq/L, chloride 110 mEq/L, bicarbonate 25 mEq/L, glucose 10 mg%, total bilirubin 0.9, LDH 375, SGOT greater than 300, and alkaline phosphatase greater than 350. Hemoglobin was 9.6 gm%, hematocrit 30%, and WBC of 8,300/mm^3 with a normal differential. Urinalysis showed pH 7.0, specific gravity 1.014, and 10 white blood cells per high power field, with culture growing E. coli in concentration greater than 10^5 per cc. Total serum T_4 was 10.3 u gm%, and T_3 resin uptake 23%. HAA was negative. Chest films, electrocardiogram, and lung scan were normal. Abdominal x-rays were remarkable for a massively enlarged liver. Liver scan showed multiple filling defects. Initial liver biopsy yielded normal tissue.

Fourteen random samples for insulin, glucagon, and glucose were obtained (Table 1).

Table 1

Case 1:

Glucose mg%	Glucagon pg/ml	Insulin μU/ml	NSILA-s %
93	166	25	
26	196	25	360 *
270	181	≤ 25	
51	372	≤ 25	280 *
66	333	≤ 25	
41	490	7	370 *
61	478	≤ 7	
90	286	≤ 25	290 *
—	109	≤ 25	
52	194	≤ 25	
92	159	8	
53	175	≤ 25	330 *

* Higher than the mean of normals in each assay group.

Due to inability to maintain adequate serum glucose levels without constant glucose infusion, therapy with 100 mg oral diazoxide every four hours was initiated. A course of 750 mg 5-fluorouracil and 950 mg streptozotocin was administered parenterally each day for five days and resulted in improved glucose levels. The patient was stabilized on 75 gm of oral sucrose every two hours. Serum glucose ranged between 30 and 50 mg% on this regimen. Thrombophlebitis developed in her left thigh and during the seventh week in the hospital she expired after an episode of sudden shortness of breath.

Postmortem Examination. Autopsy was performed within two hours of death. The lungs showed evidence of multiple fresh pulmonary emboli. The liver was massively enlarged and filled with tumor nodules, and nodes were present along the peritoneum. The pancreas and other endocrine organs, as well as the entire gastrointestinal tract, were grossly and microscopically normal. The kidneys were diffusely enlarged bilaterally. Electron and light microscopy confirmed malignant hepatoma.

Case 2. A 69-year-old white male was admitted for investigation of persistently low serum glucose. Four months previously he had undergone hemipancreatectomy at another hospital for presumed insulinoma, but microscopic examination showed pancreatic tissue to be normal. Hypoglycemia persisted despite injections of glucagon every two hours.

Examination showed a man of normal appearance with blood pressure of 125/80 mm Hg, and pulse 96/min and regular. The liver was palpable 3 cm below the right costal margin but was not enlarged. The prostate was smooth but asymmetrical and the left lobe was nodular in the area near the base.

Laboratory studies showed normal serum electrolytes, blood count, chest x-ray and electrocardiogram. Other studies including urinalysis, T_3 resin uptake, total serum T_4, liver scan, and barium enema were also normal. Radioimmunoassays for insulin repeatedly showed low levels (Table 2).

Table 2

Case 2:

5 hour GTT	2 hour GTT
Glucose mg%	Glucose mg% — Insulin μU/ml
F.B.S. — 24	F.B.S. — 24 — 1
30 — 83	30 — 114 — 7
60 — 130	60 — 150 — 5
120 — 156	120 — 104 — 2
180 — 72	
240 — 32	
300 — 30	
Serial Glucose Determination During 3600 C. Feeding	Glucose mg% — Insulin μU/ml
1:30 pm — 86	8:00 pm — 58 — 20
2:00 pm — 91	6:00 am — 47 — 10
3:00 pm — 91	8:00 am — 13 — 16
3:30 pm — 78	10:00 am — 30 — 5
8:00 pm — 30	NSILA-s — 60% higher than the mean of normals in each assay group.
12:00 am — 32	

Further tests could not be performed because of profound hypoglycemia. Treatment with 300 mg diazoxide orally every four hours was implemented for five days without effect. Steroids and frequent feeding of a high carbohydrate diet likewise had no effect. Glucagon every eight hours also elicited no significant response. Despite careful treatment with intravenous dextrose, he remained profoundly hypoglycemic and expired on the ninth hospital day.

Postmortem Examination. Bilateral pleural effusions of 250 cc and acute pulmonary edema were found. A 16 cm diameter soft tissue retrovesicular mass was found arising from the pelvic peritoneum. Microscopic examination revealed malignant mesothelioma.

Incidental finding included a moderately differentiated adenocarcinoma of the prostate with extension into the seminal vesicles. Bilateral hydronephorsis and a left staghorn calculus were also found. Endocrine organs were completely normal.

Results

During a previous admission, laboratory data had been obtained on Case 2. A two-hour and a five-hour glucose tolerance test were performed. Hypoglycemia was apparent at fasting and at four hours with glucose levels of 24 and 32 mg%. During the two-hour GTT, fasting levels of glucose were low, 24 mg%. Insulin levels were 1, 7, 5, and 2 μU/ml (Table 2).

The patient continued to be hypoglycemic despite nasogastric tube feeding and dioxide therapy of 1200 mg/d. Some random glucose values were 7 a.m.— 18 mg%, 10 a.m. — 98 mg%, 2:30 p.m. — 65 mg%, 6:30 p.m.. — 78 mg%.

Samples were obtained for NSILA-s, and values were found to be 60% higher than the mean of normals in that assay group.

Case 1 control test could not be performed because of profound hypoglycemia. Single or serial samples for glucose, glucagon, and NSILA-s were obtained daily. Higher values of glucagon (372, 333, 490 pg/ml) were found during the days of non-diazoxide therapy, although all samples where glucagon was determined were above normal values (Table 1).

NSILA-s levels in random samples were extremely high (360%, 280%, 370%, 290%, and 330% higher than the mean of normals in each assay group) (Table 1).

Insulin determinations were carried out in all samples. Results were low or undetectable. (Table 1).

Discussion

Extrapancreatic neoplasms producing severe hypoglycemia are not uncommon. In an extensive review of 180 cases from the literature[7] 45% were mesenchymal tumors located in the chest, abdomen, or pelvis; 23% were hepatomas; 10% adrenal cortical carcinomas; 8% gastrointestinal carcinomas; 6% lymphomas; and 8% miscellaneous tumors. This distribution is indeed peculiar and its importance is unknown, with some authorities[12] considering large tumor mass as one possible relationship. The two cases reported here involved a hepatoma and a mesenchymal tumor, the two most common associations found in the series. In both cases the tumor mass was large; namely 3 and 2 kilograms respectively.

The mechanism of hypoglycemia in such neoplasms has been the subject of much debate.[3,5-7] In our two cases serum NSILA-s was measured by Megyesi et al[1],[13] and in both cases it was found to be markedly elevated repeatedly in the face of low immunoreactive insulin. One can only speculate at this point that these large tumors may secrete NSILA-s and that this substance is the etiological agent resulting in severe intractable hypoglycemia.

Whether or not elevated NSILA-s is causally related to the hypoglycemia, it nevertheless appears to be specific for such tumors. There is evidence that similar tumors not associated with hypoglycemia, and insulinomas associated with hypoglycemia, have normal serum levels of NSILA-s. That elevated NSILA-s is not a result of hypoglycemia has been shown by Megyesi et al[4] when normal levels were found in controls made hypoglycemic with insulin.

We believe that from the data and from the two cases presented determinations of serum NSILA-s may prove to be of diagnostic importance in distinguishing extrapancreatic neoplasms from insulinoma, especially when the clinical picture is equivocal and serum insulin-glucose determinations are nondiagnostic. Obviously further studies are necessary to confirm the apparent specificity of elevated NSILA-s for extrapancreatic tumors.

Treatment of these tumors is a complicated matter and has yet to be satisfactorily established. Agents useful in insulinoma appear to have little effect. It is interesting that both patients were treated with diazoxide without effect. Glucagon administration in the second case likewise had no effect. 5-fluorouracil and streptozotocin appeared to have some beneficial effect in Case 1, temporarily resulting in less severe hypoglycemia, probably as a result of the general antitumor activity of these agents. We believe that measurement of NSILA-s may stimulate earlier diagnosis of these tumors and allow more time for investigation of modes of therapy.

Acknowledgements

We wish to thank Dr. Klara Megyesi of the Diabetes Branch of NIH for her contribution to this work.

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Editorial Comment ..... John I. Malone, M.D.

Hypoglycemia — Why?

The report of "Tumor Associated Hypoglycemia and Elevated Serum Nonsuppressible Insulin-Like Activity" (NSILA) in this issue of the *Journal* is the second that shows NSILA to be elevated in extra pancreatic tumors.[1]

The authors suggest that the measurement of NSILA may be helpful in distinguishing extra pancreatic neoplasms from insulinomas. When this issue arises insulin/glucose ratios greater than 200 μU/mg glucose is sufficient to distinguish in the majority of cases pancreatic from non-pancreatic tumors.[2] It is stated in the article that the measurement of NSILA-s will have its greatest importance when the insulin glucose determinations are not diagnostic. This seems wishful thinking since that question was not evaluated by these authors. However, if one examines the only other series of patients with hypoglycemia in which NSILA-s was measured by radioreceptor assay you find one patient out of three with an insulinoma and an elevated NSILA-s.[1] Thus with only limited use, this test has already produced some misleading diagnostic information. It seems likely that this laboratory test will also provide its share of equivocal results if it is utilized for the evaluation of a large number of patients. This should be reassuring for those who continue to hope that physicians will always be required to correlate that laboratory data with the patient.

In contrast to the authors' conclusion it seems that the most important function for the radioreceptor assay of NSILA is as a research tool. The source and metabolic fate of NSILA remains to be determined. Do tumors associated with elevated levels of NSILA-s produce increased quantities of this substance or an inhibitor of its turnover? What are the levels of NSILA in patients with non-tumor associated hypoglycemia such as liver failure?

This particular assay at present seems to have greater usefulness as a tool for understanding insulinopenic hypoglycemia than as a diagnostic tool for extra pancreatic tumors causing hypoglycemia.

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Rebuttal ..... Albert Castro, Ph.D.

The reviewer has misinterpreted data from the only previous report on NSILA-s in patients with tumor associated hypoglycemia. Moreover, physicians who encounter these patients will readily acknowledge that insulin/glucose ratios do not always provide discriminatory information. To have available an additional study, like the NSILA-s assay, could be helpful, particularly in patients with lesions that are small and relatively inaccessible clinically.

Microsurgical Neurovascular Decompression for Trigeminal Neuralgia and Hemifacial Spasm

Albert L. Rhoton Jr., M.D.

Abstract: This report reviews a significant advance in the treatment of two cranial nerve hyperfunction syndromes: the neurovascular decompression of the fifth cranial nerve for trigeminal neuralgia and the seventh cranial nerve for hemifacial spasm. These operations give excellent results with few side effects and represent the treatment of choice in selected patients. This report concerns ten patients with trigeminal neuralgia and five patients with hemifacial spasm treated by these methods. The procedures should be done using microsurgical techniques.

Dandy, in 1934, postulated that arterial compression and distortion of the trigeminal and facial nerves might be the cause of the hyperfunction syndromes of these nerves which are manifested by the spontaneous paroxysms of pain of trigeminal neuralgia and the involuntary facial muscular contractions of hemifacial spasm.[1] The vascular compression theory failed to gain acceptance at the time but awaited the better demonstration of these pathological changes. The careful documentation of these changes at surgery, using magnification provided by the operating microscope, has led to the realization of the importance of these pathological changes and the development of the new operative approach outlined here.[2,3]

Trigeminal Neuralgia

Trigeminal neuralgia is an excruciating paroxysmal facial pain provoked by facial stimuli, confined to the trigeminal zone, and not associated with sensory loss. The pain is often described as stabbing or lightening-like and lasts only a few seconds to a few minutes. On physical examination, there are no abnormal findings except for provocation of the pain by stimulation of a trigger zone. The finding of any deficit on neurological examination should suggest the possibility of some other disease. The diagnosis is made solely on the history and description of the pain and is notable for the absence of abnormal findings on physical or radiologic examination.

The medical treatment of trigeminal neuralgia, although initially effective, often proves to be unsatisfactory. Diphenylhydantoin and carbamazepine will often give relief; however, most patients eventually become refractory to the former and the necessity of frequently testing hematopoietic and hepatic function and the high incidence of side effects with the latter lead to patients becoming dissatisfied with it.

When medical therapy fails or has been found inappropriate, and when the patient for medical or other reasons is not felt to be a satisfactory candidate for a major operative procedure, peripheral neurectomy and alcohol injections have been tried. These procedures give only temporary relief, lasting an average of 8-16 months because the lesion, being peripheral to the ganglion, allows the nerve to regenerate. Radiofrequency stereotaxic lesions, as we have reported recently, overcome the need for general anesthesia and major surgery, and because the lesion is in the ganglion and posterior root, rather than in the peripheral branches, the likelihood of recurrence of pain is reduced.[4] The procedure is accomplished by the placing of an electrode through the foramen ovale into the central root of the trigeminal nerve and producing destruction of one or more divisions of the nerve using a radiofrequency current. We recommend radiofrequency lesions in the majority of elderly patients. However, this procedure is accompanied by numbness of the face which some patients find disagreeable. Retrogasserian section of the trigeminal nerve through a subtemporal craniectomy has been the most widely accepted intracranial operation of the past, and although the relief is permanent, the side effect of facial numbness is the same as that associated with the radiofrequency lesion.

Recently, in the patient wishing to be spared the side effects of facial numbness, we have started to do the operation called the posterior fossa neurovascular decompression of the trigeminal nerve (Fig. 1). Since 1968, Jannetta, using the operating microscope, has perfected the operation and clearly demonstrated the pathologic arterial changes in trigeminal neuralgia: that the fifth cranial nerve is compressed at its exit from the brain stem by an artery, usually the superior cerebellar or anterior inferior cerebellar artery or by a vein.[3] He demonstrated that dissection of the vascular structure from its encroachment on the nerve dampens the pulsation effect to give pain relief without loss of

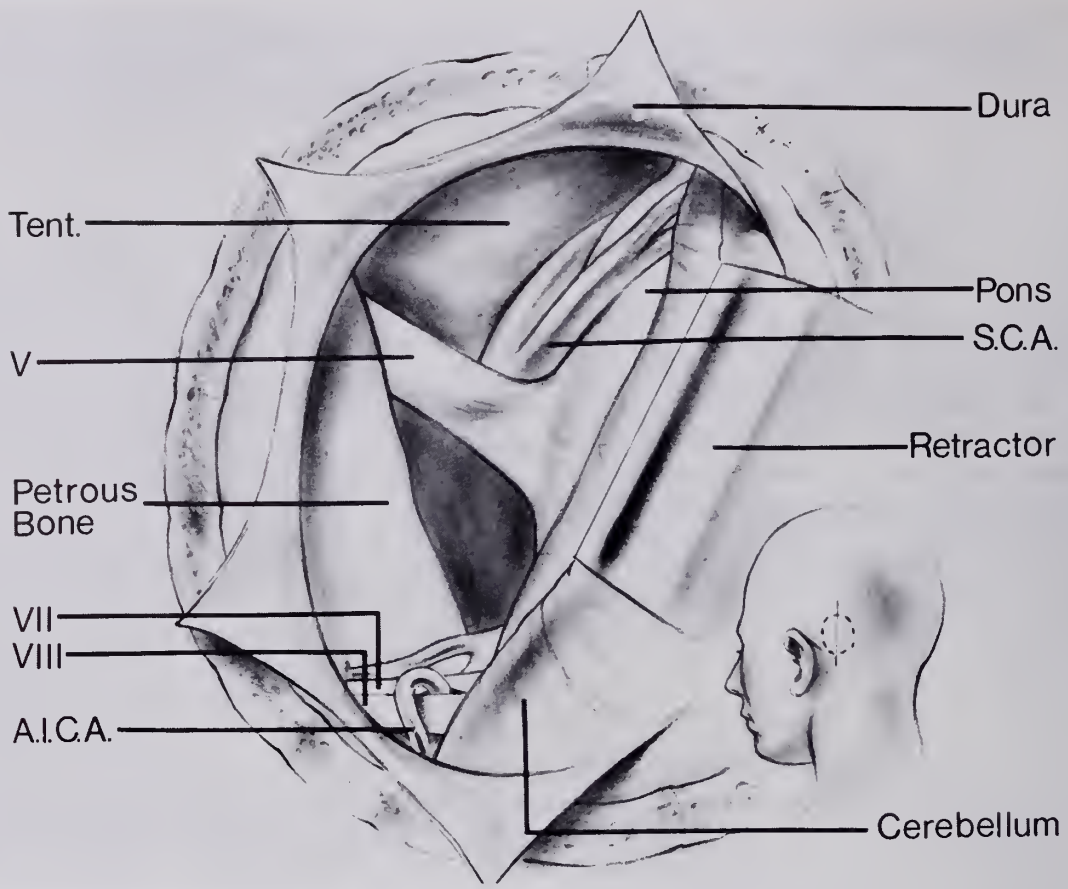


Fig. 1 — Exposure of left cerebellopontine angle showing typical findings in trigeminal neuralgia; the trigeminal nerve (V) is compressed by the superior cerebellar artery (SCA). Insert on lower left shows skin incision (solid line) and bone opening (dotted line). Tentorium (Tent.) above the trigeminal nerve. Facial (VII) and acoustic nerves (VIII) below separated by loop of anterior inferior cerebellar artery (AICA). Retractor on cerebellum.

sensation in the face. The procedure is carried out under general endotracheal anesthesia with the patient in the sitting position. Hair is shaven from only the portion of the head behind the ear on the side of the surgery. A vertical incision is made behind the ear on the side of the pain and a suboccipital craniectomy of approximately 4 cm in diameter is done exposing the margins of the transverse sinus. The dura is opened to expose the lateral cerebellum. The operating microscope is then brought into the procedure and the arachnoid is opened and the fifth cranial nerve is exposed using magnification. The offending artery is identified and may be either above or below the nerve. In second and third division neuralgia, the most common varieties, the artery is found above the nerve. The arachnoid is removed from both the artery and the nerve and the artery is carefully elevated and displaced from the nerve. A small pledget of synthetic inert sponge is placed between the artery and the nerve.

Since September 1976 we have done ten operations in eight women and two men. All the patients obtained relief of pain. The patients were usually discharged from the hospital in seven to nine days. There have been no complications, no cerebellar signs, and no recurrence of pain in this group. We now use this procedure routinely in the younger patient wanting to avoid facial numbness. We continue to perform the percutaneous radiofrequency lesion in the elderly patient or in those who have associated medical conditions which complicate the general anesthetic risk.

Hemifacial Spasm

Hemifacial spasm is an involuntary spasmodic contraction of the muscles of the face which results in an unsightly grimacing. Patients may be threatened with loss of employment because of the cosmetic disfigurement or because involuntary eye closure affects their ability to drive, read or concentrate. It is usually not associated with other neurologic deficit nor is it painful. If not treated a slight facial weakness may develop over a period of years. A tumor or aneurysm compressing the facial nerve is known to be the cause of a small percentage of cases of hemifacial spasm. However, it

was not until surgical magnification was routinely applied in examining the involved nerves in the cerebellopontine angle that Jannetta was able to routinely demonstrate arterial compression of the nerve in this condition by the vertebral, anterior inferior or the posterior inferior cerebellar artery.[2] There is no satisfactory medical therapy. Because of the seriousness of the problem, numerous surgical therapies have been applied, but most have been unsuccessful. Most operations have been designed to injure the facial nerve, thereby substituting facial weakness for facial hyperactivity. In the older, destructive operations, the facial nerve was partially sectioned either in its main trunk between the stylomastoid foramen and parotid gland or more distally at its ramifications in the face. Regeneration of the nerve after these procedures was often followed by recurrence of the spasms.

The posterior fossa neurovascular decompression was designed to treat the condition without producing facial weakness. The same operative exposure is used as for decompressing the trigeminal nerve in the treatment of trigeminal neuralgia (Fig. 2). The approach after opening the dura is directed somewhat lower to reach the seventh and eighth nerves rather than the fifth nerve. Using magnification, the compressing arterial loop located at the point of entrance of the facial nerve into the brain stem is exposed. The artery is dissected from the nerve and a prosthesis is placed between the nerve and the artery. The retractors are removed from the cerebellum and, in order to make certain that the prosthesis does not become displaced, the retractor is then reinserted and the area reexamined to make sure that the sponge is firmly fixed in place.

Postoperatively, the patient's spasms usually subside over several weeks. Some impairment of hearing has been reported by others following the procedure, although the author has not experienced this complication.[5] Since January 1976 we have used this procedure in five patients: two men and three women. All patients had a history of progressively severe spasms over a period of three years or longer. Four of the five patients have experienced complete relief of their facial spasms. One patient is improved but has some residual spasms. There have been no complications in this group.

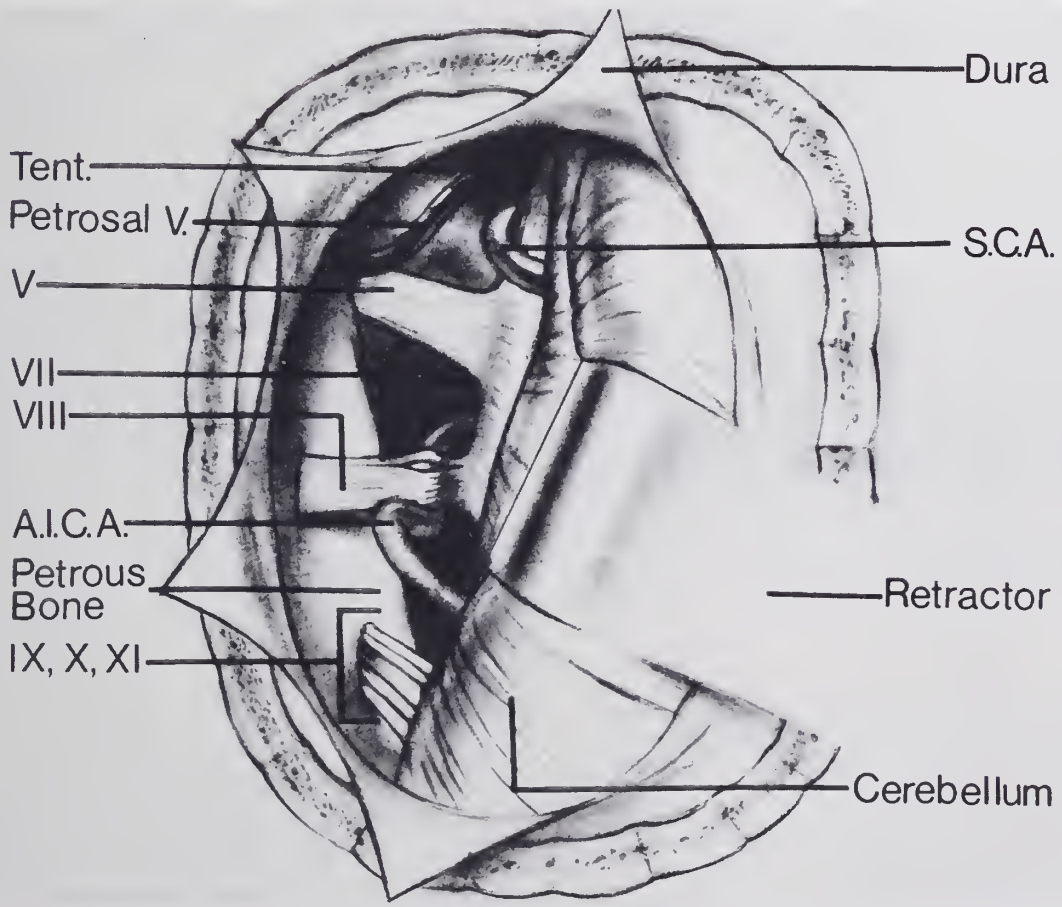


Fig. 2 — Exposure of left cerebellopontine angle showing typical operative finding in a case of hemifacial spasm. Skin incision and bone opening the same as in Figure 1. A loop of the anterior inferior cerebellar artery (AICA) compresses facial (VII) and acoustic nerves (VIII). Tentorium (Tent.), superior cerebellar artery (SCA), petrosal vein (Petrosal V) and trigeminal nerve (V) seen above facial nerve; ninth (IX), tenth (X) and eleventh (XI) nerves seen below. Retractor on cerebellum.

Discussion

We have found the results obtained with these two procedures especially gratifying. The posterior fossa neurovascular decompression in trigeminal neuralgia, although it requires a general anesthetic and is a major operative procedure, avoids the undesirable side effect of permanent facial numbness which often continues to be a disagreeable feature of other methods of surgical treatment. A recurrence rate of approximately 5% has been reported by Jannetta and is no greater than that associated with any other form of surgical therapy which has the potential of giving permanent relief.[3] We now routinely recommend the neurovascular decompression procedure for the younger patient who wants to avoid facial numbness. The percutaneous stereotaxic radiofrequency trigeminal nerve lesions are routinely used for the elderly patient willing to accept numbness but wanting to avoid a major operative procedure in order to obtain permanent relief.

The experience has been especially rewarding in the patients with hemifacial spasm for in the past there has been no satisfactory medical treatment, and surgical treatment has often resulted in a facial palsy, usually associated with recurrence of the spasms after the facial palsy recovered.

Microoperative techniques are needed to minimize the operative risk attendant to these procedures. These techniques allow the nerves to be exposed through smaller cranial openings and they minimize the amount of brain retraction needed to define the site of compression. The nerves are usually compressed at the entry of the nerve into the brain stem, an area where dissection should be carefully and gently completed using the intense light and magnification provided by the surgical microscope.

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Editorial Comment ..... Gene A. Balis, M.D.

"Microsurgical Neurovascular Decompression for Trigeminal Neuralgia and Hemifacial Spasm" is a good brief review for the medical community. It is important that the non-neurological specialist be aware of the different modes of approach to the patient with trigeminal neuralgia and hemifacial spasm. The operative technique described by Dr. Rhoton and popularized by Janetta, should be made available in the case of the younger patient in trigeminal neuralgia to prevent facial numbness. Similarly in hemifacial spasm, the varied surgical therapies have been tried with facial weakness and recurrence of spasm being the results. However, with the technique reviewed by Dr. Rhoton, this complication, hopefully, will not occur.

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Editorial Comment ..... Nelson Liss, M.D.

This is an excellent presentation of a relatively new technique for treating two rare and difficult problems. It is scientifically accurate although the vascular compression theory for trigeminal neuralgia is still not universally accepted.

Dr. Liss is in the private practice of Neurology in Lauderdale Lakes.

Pulmonary Function Testing in Florida What's Available and How to Use It

Douglass A. Morrison, M.D. and Allan L. Goldman, M.D.

Pulmonary function testing is becoming increasingly available to clinicians, yet many physicians are not familiar with these tests. This article outlines the current use of commonly used tests and indicates some of the hospitals in Florida which perform them.

Functional abnormality often does not correlate with clinical or radiographic abnormalities, so pulmonary function testing can be quite helpful in determining pulmonary abnormality, for example, in assessment of dyspnea. In this regard it can be essential for evaluating occupational hazard, disability, response to therapeutic modalities or operative risk. Two excellent reviews have summarized the general uses of pulmonary function testing.[1,2]

Specific Tests

Arterial Blood Gases

Arterial blood gases usually include the partial pressure of oxygen (PaO_2), the partial pressure of carbon dioxide ($PaCO_2$) and the pH. Blood gases are most important in the diagnosis of respiratory failure ($PaO_2 \leq 50$ mmHg and/or $PaCO_2 \geq 50$ mmHg) and in assessing its response to therapy.[3,4] The effectiveness of oxygen therapy and mechanical ventilation can only be assessed by blood gas analysis.[5] In general, we aim for a PaO_2 of 60 mmHg to 80 mmHg with a normal pH.

An elevated PaO_2 (>100 mmHg) occurs only with supplemental oxygen or severe hyperventilation. Hypoxemia ($PaO_2 < 80$ mmHg) is a common problem resulting from diverse cardiopulmonary pathology. Table 1 categorizes the types of defects which produce hypoxemia. Of these, the most commonly encountered clinically is ventilation perfusion mismatching.[6]

The $PaCO_2$ serves as an index of alveolar or effective ventilation. An elevated $PaCO_2$ (> 45 mmHg) is tantamount to alveolar hypoventilation and a depressed $PaCO_2$ (< 35 mmHg) to hyperventilation.[7] Table 2 gives common clinical examples of each.

The pH measurement provides an assessment of the acid-base status of the patient. Acidosis (pH < 7.35) may be primarily respiratory ($PaCO_2$ > 45 mmHg) or metabolic (HCO_3 <24 mEq/L). Alkalosis (pH > 7.45) may be primarily respiratory ($PaCO_2$ < 35 mmHg) or primarily metabolic (HCO_3 > 28 mEq/L). Mixed disturbances and further details are discussed elsewhere.[7,8]

Spirometry

Spirometry consists of a graphic recording of the patient's maximal forced expiration over time. From this graph we obtain four extremely valuable pieces of information: (1) the total volume that can be forcefully exhaled (forced vital capacity or FVC); (2) the forced expiratory volume in one second (FEV_1); (3) the ratio of FEV_1/FVC and, (4) the slope of the middle half of the curve known as the forced expiratory flow from 25% to 75% of the FVC ($FEF_{25-75\%}$).

Spirometry is the single most useful parameter with which to diagnose disease, follow therapy, evaluate preoperative risk and assess prognosis in patients with obstructive lung disease (asthma, chronic bronchitis, emphysema, cystic fibrosis and bronchiectasis).[9,10] It is safe, simple, quick, reproducible and provides clinically useful information that cannot be reliably inferred from other clinical or roentgenologic procedures.[9] It is frequently useful to obtain spirometry before and after a bronchodilator, i.e., isoproterenol, if the patient has airway obstruction (FEV_1 < 80% of predicted). An increase of ≥ 15% of the FEV_1 is evidence of reversible airways obstruction and suggests that the subject will respond favorably to bronchodilator therapy. It must be emphasized, however, that the absence of response does not preclude therapeutic benefit from bronchodilator therapy or corticosteroids.

Lung Volumes

After a maximal expiration there is still some air left in the lung. It is the residual volume (RV) and the amount left after a normal tidal expiration is the functional residual capacity (FRC) of the lung. We must measure one of these volumes (RV or FRC) in order to combine it with a spirometric tracing to obtain the total lung capacity (TLC) which is the sum of the vital capacity and RV. The most common method of doing this is to have the subject inhale from a closed system a known concentration of inert gas (not absorbed by the lung)

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Table 1. — Cause of Hypoxemia (Arterial pO_2 < 80 mmHg).

Mechanism	Confirmatory Evidence	Clinical Implication	Common Disease States
1. Hypoventilation	Elevated $PaCO_2$	O_2 may be helpful but primary objective is to increase patients' ventilation either mechanically or by treating underlying abnormality.	Drug overdose, high spinal cord lesion, chronic obstructive lung disease
2. Right to left shunt	While breathing 100% O_2 arterial pO_2 < 550 mmHg	O_2 often will not improve blood gases	Cyanotic heart disease, adult respiratory distress syndrome
3. Diffusion defect	Diffusion capacity < 40% predicted	Responds to O_2	Severe interstitial disease, i.e. sarcoid Hamman-Rich, etc.
4. Ventilation perfusion mismatching		Responds to O_2 and treatment of underlying abnormality	Chronic obstructive pulmonary disease, congestive heart failure

such as helium. By measuring the final concentration and knowing the temperature, barometric pressure and original volume of the helium, one can compute the unknown volume (FRC or RV) of the lung.[6,8]

Clinical Uses of Spirometry and Lung Volumes

Using spirometry and lung volumes we can divide most pulmonary function abnormalities into one of three major categories: obstructive, restrictive or combined.[11] First the FEV_1, FVC, RV and TLC are compared with normal values based on age, sex, height and race.[9,12,13] Generally 80-120% of the predicted value is accepted as the "normal range." Then, by the criteria outlined in Table 3, the category of disease and degree of severity are determined.

There is considerable recent interest in determining who will develop clinically significant obstructive lung disease. It is by no means established that "small airways dysfunction" is a precursor to significant airways obstruction.[14,15] In terms of spirometry and lung volumes small airway dysfunction is said to be present when the FEV_1 is normal and either the RV is increased or the $FEV_{25-75\%}$ is decreased.

Another use of spirometry is in preoperative assessment, particularly in patients who are felt to have significant pulmonary pathology.[16] As a general rule of thumb, for example, one can anticipate a decline of vital capacity in the immediate postoperative period of approximately 25% with lower abdominal surgery, approximately 50% with upper abdominal surgery and approximately 75% with thoracic surgery. Because of this if the preoperative vital capacity is less than 1.5 to 2 litres the patient must be closely observed for postoperative respiratory failure.

Diffusing Capacity

Tests of the uptake of carbon monoxide (CO) by the lung are intended to infer the area of gas exchange, the thickness of the alveolar capillary membrane and the capillary volume. In most situations the single breath diffusion capacity (D_{CO}) is employed. In this test the

Table 2. — Common Clinical Etiologies of Hyper and Hypoventilation.

Hyperventilation ($PaCO_2$ < 35 mmHg)	Hypoventilation ($PaCO_2$ > 45 mmHg)
Psychogenic	CNS depression, i.e. drug overdose
Fever	High spinal cord lesion, i.e. transverse myelitis
Anemia	Motor neuron lesion, i.e. poliomyelitis
Pregnancy	Peripheral neuropathy, i.e. Guillain-Barre
Thyrotoxicosis	Impaired neuromuscular transmission
Hepatic Failure	Muscle weakness, i.e. dermatomyositis
Gram Negative Sepsis	Chest wall abnormality, i.e. scoliosis
Lung Diseases, i.e.	Upper airway obstruction, i.e. laryngospasm
Pulmonary Edema, mild	Lower airway disease, i.e. chronic bronchitis
Pulmonary Embolism	Intrathoracic nonparenchymal, i.e. pleural effusion
	Parenchymal, i.e. pneumonia

Table 3. — Obstructive vs. Restrictive Ventilary Defect.

	Obstructive	Restrictive
Spirometry	FEV_1 < 80% predicted FVC ↓ or normal FEV_1/FVC < 75%	FVC < 80% predicted FEV_1 normal or ↓ and FEV_1/FVC > 75%
Lung Volumes	RV > 120% predicted TLC normal or ↑	TLC < 80% predicted
Clinical Examples	Emphysema Chronic bronchitis Cystic fibrosis Asthma (during attack) Bronchiectasis	Pulmonary edema Pulmonary fibrosis Pleural effusion Lung resection

subject inspires a known volume and concentration of CO and helium (to correct for lung volume), holds his breath and exhales into a collecting system which measures the concentrations and from which the uptake of CO can be computed.[7,9] The patient must be able to hold his breath for 10 seconds and have a sufficiently large vital capacity (> 1.5 L) to clear the "dead space." The value will be affected by hemoglobin level (i.e., anemia decreases it; polycythemia increases it) and the subject's own level of carbon monoxide (i.e., heavy smoking can decrease it).

In emphysema where extensive tissue destruction occurs, the D_{CO} is decreased whereas it is normal in

Table 4. — Pulmonary Function Tests Performed in Florida Hospitals.

	Beds	ABGs	Spirometries	Lung Volumes	Diffusion	Exercise	Control Breathing
Bethesda Memorial	300	Yes	Yes	Yes	No	No	No
Pembroke Pines	301	Yes	Yes	Yes	No	No	No
Hubert Rutland	301	Yes	Yes	No	No	No	No
Memorial of Jacksonville	303	Yes	Yes	Yes	Yes	Yes	No
Sacred Heart, Pensacola	310	Yes	Yes	Yes	Yes	Yes	Yes
Palms of Pasadena	310	Yes	Yes	Yes	No	No	No
Mease, Dunedin	310	Yes	Yes	Yes	No	No	No
West Florida, Pensacola	317	Yes	Yes	Yes	Yes	Yes	No
Good Samaritan, West Palm	317	Yes	Yes	Yes	Yes	No	No
Naval Regional, Pensacola	317	Yes	Yes	Yes	No	Yes	No
North Miami General	321	Yes	Yes	Yes	No	No	No
Coral Gables	321	Yes	Yes	Yes	No	Yes	No
Naval Regional, Jacksonville	330	Yes	Yes	Yes	Yes	No	No
Brevard Hospital	332	Yes	Yes	Yes	Yes	Yes	No
Hollywood Medical Center	334	Yes	Yes	Yes	No	No	No
North Broward	336	Yes	Yes	No	No	No	No
North Shore, Miami	358	Yes	Yes	Yes	Yes	No	No
North Ridge General	396	Yes	Yes	Yes	Yes	No	No
Hialeah Hospital	411	Yes	Yes	Yes	Yes	Yes	No
American Hospital	412	Yes	Yes	Yes	Yes	No	No
St. Anthony's, St. Pete	434	Yes	Yes	Yes	Yes	Yes	No
VAH, Lake City	445	Yes	Yes	Yes	Yes	Yes	No
Tallahassee	458	Yes	Yes	Yes	No	No	No
VAH, Gainesville	468	Yes	Yes	Yes	Yes	Yes	Yes
Shands, Gainesville	472	Yes	Yes	Yes	Yes	Yes	No
St. Vincents, Jacksonville	482	Yes	Yes	Yes	Yes	Yes	Yes
Halifax Hospital, Daytona	495	Yes	Yes	Yes	Yes	No	No
Baptist Hospital, Miami	513	Yes	Yes	Yes	Yes	No	Yes
South Miami	528	Yes	Yes	Yes	Yes	Yes	No
Lee Memorial, Ft. Myers	558	Yes	Yes	No	No	Yes	No
Baptist Memorial, Jacksonville	567	Yes	Yes	Yes	No	No	No
Morton Plant, Clearwater	600	Yes	Yes	Yes	No	Yes	No
Tampa General	602	Yes	Yes	Yes	Yes	Yes	No
Memorial, Sarasota	624	Yes	Yes	Yes	Yes	Yes	No
VA Center, Bay Pines	673	Yes	Yes	Yes	Yes	No	No
VAH, Tampa	697	Yes	Yes	Yes	Yes	Yes	Yes
Mount Sinai	724	Yes	Yes	Yes	Yes	Yes	No
Miami VAH	870	Yes	Yes	Yes	Yes	Yes	Yes
Lakeland General	897	Yes	Yes	Yes	No	No	No
Cedars of Lebanon	924	Yes	Yes	Yes	Yes	No	Yes
Jackson Memorial	1250	Yes	Yes	Yes	Yes	Yes	Yes

chronic bronchitis or asthma. In interstitial lung diseases (sarcoid, connective tissue diseases, pneumoconiosis, etc.) and diseases of the pulmonary vasculature (pulmonary emboli), the D_{CO} is very valuable in early diagnosis and in following the response to therapy.

Other Tests

Tests of the distribution of ventilation, control of ventilation and exercise stress tests are less useful in clinical practice at this time either because of the need for more complicated equipment; the requirement of increased physician, technician and patient time; difficulties in interpretation or expense. These tests are discussed in greater detail elsewhere.[8]

Tests Available in Florida

Some or all of the above mentioned tests are performed in many hospitals, clinics and doctor's offices. Table 4 is a list of Florida hospitals of greater than 300 beds (from the Directory of the Florida Medical Association, 1977) that responded to our letter of inquiry concerning available pulmonary function testing.

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Pronouncement of Death Not Necessary Under Florida Law

Florida Law does not require official pronouncement of death, according to an opinion by Atty. Gen. Robert L. Shevin.

However, a death certificate listing the cause of death must be filed with the local registrar within three days of discovery. Only the attending physician, a medical examiner or a coroner may sign certifications of cause of death.

Mr. Shevin's opinion was in response to an inquiry from Volusia County officials who asked if a sheriff, deputy sheriff or emergency medical technician has the legal authority or duty to declare a person who dies unattended by a physician officially dead.

The Attorney General stated that these individuals have neither authority nor responsibility — and consequently no immunity from liability — under these circumstances.



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SPECIAL ARTICLES

Maternal Deaths in Florida, 1975 and 1976
A Maternity Mortality Committee Study

Samuel L. Renfroe, M.D. and G. Robert Bowers, M.P.H.

Abstract: Thirty-nine maternal deaths in Florida were reported during the two-year period January 1975 — December 1976. From case histories the Florida Maternal Mortality Committee attributed 34 of the deaths to factors directly or indirectly related to pregnancy. A thorough review could not be conducted in three cases due to insufficient information and two deaths were not related to pregnancy. The Committee concluded that 15 deaths may have been prevented. Of these hemorrhage caused eight, toxemia one, infection one, vascular accident two, and cardiac disease three. The triad of hemorrhage, infection and toxemia is beginning to disappear; however, hemorrhage remains the leading cause of death. Age, race, marital status and parity continue to be significant indicators for determinig risk of maternal mortality.

Beginning in 1960 the Florida Medical Association directed its Committee on Maternal Mortality to survey maternal deaths annually to determine trends and factors of preventability. This was done in coordination with the Florida State Board of Health's obstetrical consultant until 1974; then the Committee's functions were delegated to the Division of Health, successor to the Board of Health, and later to the Health Program Office of the Department of Health and Rehabilitative Services.

This report presents findings of the Committee for a two-year period — January 1975 through December 1976.

Dr. Renfroe is Chairman of the Maternal Mortality Committee and Mr. Bowers is a staff assistant from the Family Health Program.

Materials

The Florida Vital Statistics Program sends a copy of each death certificate indicating a pregnancy-related death to the Family Health Program, a part of the Health Program Office, which in turn contacts the attending physician for additional information. It encloses a copy of the Florida Statutes which explains the physician's exemption for liability for releasing this information and guarantees confidentiality of the patient's identity. Correspondence with him is maintained until the case file includes a completed survey form, copy of the autopsy protocol, and other relevant data such as anesthesia report and narrative summary. A copy of each file is sent to members of the Maternal Mortality Committee after identity of physician, patient and hospital has been removed.

During the FMA annual meeting, Committee members determine the actual cause of death from the accumulated records, possible preventability, and the agent or agents which may have prevented the death. They also decide whether the death was related directly or indirectly related to the pregnancy or not related, according to criteria of the Committee on Maternal and Child Care of the American Medical Association.

Results

During the two-year period 210,334 live births were reported in Florida and 39 maternal deaths — 12 white and 11 nonwhite in 1975 and six white and ten nonwhite in 1976. Sufficient information for a thorough review could not be obtained in three 1976 cases and an additional two cases had nonobstetrically related causes of death. Findings in terms of classification of death are shown in Table 1.

Table 1. — Maternal Mortality Rates in Florida, 1975-1976.

Live Births	210,334
Maternal Deaths	39
Direct causes	27
Indirect causes	7
Unrelated causes	2
Not classified	3
Rate (direct only)	12.8/100,000 live births
Rate (direct and indirect)	16.2/100,000 live births
Rate (all causes)	18.5/100,000 live births

Table 2. — Resident Maternal Deaths and Maternal Mortality Rates per 10,000 Live Births, by Race, Florida, 1950, 1960, 1966-1976.

	DEATHS			RATES		
		White	Nonwhite		White	Nonwhite
1950	83	34	49	12.9	7.4	26.2
1960	58	17	41	5.0	2.0	13.1
1966	41	19	22	4.0	2.6	7.5
1967	26	8	18	2.6	1.1	6.6
1968	40	15	25	3.9	2.0	9.4
1969	29	12	17	2.7	1.5	6.4
1970	35	21	14	3.0	2.4	5.0
1971	34	17	17	2.9	2.0	5.7
1972	24	9	15	2.2	1.1	5.3
1973	23	10	13	2.1	1.3	4.6
1974	15	6	9	1.4	0.7	3.2
1975	23	12	11	2.2	1.5	4.0
1976	16	6	10	1.5	0.8	3.6

Source: Florida Vital Statistics Report, 1975 and 1976.

Table 3. — Maternal Mortality Rates per 10,000 Live Births; Comparison of Florida Rates to Total United States Rates.

	Florida Rates	United States Rates
1950	12.9	8.3
1960	5.0	3.7
1966	4.0	2.9
1967	2.6	2.8
1968	3.9	2.5
1969	2.7	2.2
1970	3.0	2.2
1971	2.9	1.9
1972	2.2	1.9
1973	2.1	1.5
1974	1.4	2.1
1975	2.2	1.3
1976	1.5	Not Available

Sources: Florida Vital Statistics Report, 1975 and 1976.
U.S. Dept. HEW, Vital Statistics Report, Provisional Statistics, Annual Summary for U.S., 1975.

The maternal death rate for 1975 (deaths per 10,000 live births) rose to 2.2, an increase of 57% over the previous year and declined to 1.5 in 1976, approximating the rate for 1974. Table 2 depicts rates for the total population and white and nonwhite for 1950, 1960, and the decade prior to 1976.

The rate has been consistently above that for the nation. Table 3 shows the variations between the rates for the past decade as well as for 1950 and 1960. The rate for Florida dropped below the national rate for the first time in 1974; however, in 1975 the rate was 0.9 per 10,000 live births higher than the national rate. The 1976 rate should come close to the national rate. Since the actual number of deaths is small, slight increases in any one year make a significant change.

The rate for unwed mothers (number of unwed mortality cases per 100,000 live births to unwed mothers) is 36 as compared to 9.5 for married women (Table 4). Age serves an important role. The age specific death rate (number of maternal deaths in each age group per 100,000 live births to women in each age group) increased dramatically with the age of the patient.

The rate shows an unusual trend when calculated by parity (number of maternal deaths by parity per 100,000 live births in each parity group). The rate was approximately equal for women with a parity of 1 or 3 live-born while mortality for women with a parity of 2 live-born was relatively lower. The rate for women with a parity of 4 or more live-born was more than double that of women with a parity of 3.

What was once the triad contributing to maternal deaths, hemorrhage, toxemia and infection, is no longer strongly evident (Table 5). Although hemorrhage accounted for 40.7% of the direct causes of mortality, the incidence of toxemia and infection was significantly reduced. Vascular accidents, on the other hand, climbed to a close second place accounting for 37% of direct causes of death.

The diagnosis of 29 of the 34 cases studied was confirmed by autopsy. Of direct causes, hemorrhage caused 11 deaths, toxemia two, infection two, vascular accident ten, anesthesia one, and hepatic insufficiency one. Of indirect causes, cardiac disease accounted for three deaths, vascular disease two, urinary tract disease one, and hemorrhagic pancreatitis one. Two deaths, one resulting from pulmonary thromboembolism and one from subarachnoid hemorrhage, were non-pregnancy related. The Committee concluded that 15 deaths may have been prevented.

In 47% of the cases the pregnancy resulted in a live birth. Eight cases had cesarean section. Pregnancy outcome for the remainder obviously either was stillborn or undelivered.

Table 4. — Demography of Maternal Deaths, Direct and Indirect Causes, Florida, 1975 and 1976.

Demographic Group	Number Maternal Deaths	Percent All Pregnancy Related Maternal Deaths	Maternal Deaths per 100,000 Live Births in Each Demographic Group
Race:			
White	16	47.1	10.3 per 100,000 white births
Nonwhite	18	52.9	32.4 per 100,000 nonwhite births
Marital Status			
Married	16	47.1	9.5 per 100,000 births to married women
Unwed	15	44.1	36.0 per 100,000 births to unwed women
Not stated	3	8.8	—
Age			
Under 20	4*	11.8	8.5 per 100,000 births to women under 20
20 — 34	21	61.8	13.6 per 100,000 births to women aged 20-34
35 — 44	8	23.5	91.4 per 100,000 births to women aged 35-44
Over 44	1	2.9	1086.9 per 100,000 births to women over 44 years old
Parity			
0	7	20.6	—
1st born	10	29.4	12.0 per 100,000 1st born births
2nd born	4	11.8	7.0 per 100,000 2nd born births
3rd born	3	8.8	11.9 per 100,000 3rd born births
4th born	3	8.8	29.2 per 100,000 4th born births
5th or more born	3	8.8	30.0 per 100,000 5th born or higher births
Unknown	4	11.8	—

* The ages of these girls are 13, 17, 18, and 19.

Table 5. — Classification of Maternal Deaths by Diagnosis, Direct Causes of Death, Florida, 1975 and 1976.

Diagnosis	Number Cases	Percent Total Direct Causes of Death	Percent Total Maternal Deaths
Hemorrhage	11	40.7	28.2
Ectopic Pregnancy	5	18.5	12.8
Abruptic Placenta	2	7.4	5.1
Laceration of Uterus	1	3.7	2.6
Intracerebral Hemorrhage	1	3.7	2.6
Incomplete Abortion	1	3.7	2.6
Placenta Accreta	1	3.7	2.6
Toxemia (Eclampsia)	2	7.4	5.1
Infection (Septicemia)	2	7.4	5.1
Vascular Accidents	10	37.0	25.6
Amniotic Fluid Embolism	3	11.1	7.7
Pulmonary Thromboembolism	3	11.1	7.7
Cerebral Thrombosis	1	3.7	2.6
Disseminated Intravascular Coagulation	3	11.1	7.7
Anesthesia (Aspiration)	1	3.7	2.6
Other (Hepatic Insufficiency)	1	3.7	2.6
TOTAL	27	—	69.2

Discussion

Maternal deaths have decreased sufficiently to prohibit a detailed statistical analysis based upon one year findings. Considering the rapid advancement in technology and understanding of obstetrics, long-range longitudinal studies are relatively invalid. As a result, this report amalgamates two consecutive years. The cases incorporate the more modern practice of obstetrics and at the same time compose a larger baseline sample.

Even with a two year sample, the actual number of cases is still significantly small, thus severely limiting the statistical value of the data. Therefore, this report is not intended to be conclusive evidence of the state of obstetrical care in Florida. It is, however, an informative study highlighting the trends of obstetrical care.

Two uncontrollable factors limit the validity of the study. Pregnancy-related deaths, particularly those having an indirect cause, often are not reported on the death certificate. Information supplied in response to inquiries is incomplete. The question of confidentiality often is the reason for limited response to inquiries. Committee members need reasonably in-depth information such as autopsy protocols, anesthesia and surgery reports as well as the patient's history.

The purpose of the Committee's review is not to critique the practice of individual physicians but rather to study the background factors surrounding each case. The identification of common factors in conjunction with an improved program of informing physicians of common causative factors should lead to a near complete eradication of preventable maternal deaths.

To improve the validity of its future studies, the Maternal Mortality Committee has requested that physicians indicate on the death certificate, when appropriate, that the death occurred during pregnancy or within 90 days of a pregnancy termination. Additionally, physicians are encouraged to support the efforts of the Committee by forwarding all pertinent records and reports relating to a maternal mortality case when contacted. The Committee depends entirely on the thoroughness of the physicians' responses.

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AMERICAN RED CROSS CAMPAIGN

Safeguarding Your Prescription Pads and Games Addicts Play

Laurin G. Smith, M.D.

Florida physicians concerned about the drug abuse problem should be aware of the various devices addicts employ to obtain narcotics, barbiturates and hypnotics legitimately for illegal street use. Theft of prescription pads is increasing in incidence. Hemostats and forceps are disappearing from examining rooms. Marijuana smokers take them to use as "roach clips" for holding the cigarette when it becomes too short to handle with the fingers.

The prescription pad in the examining room or hospital is readily seen, easily picked up and removed. In the office the physician should carry the pad in his lab coat or jacket pocket and lock the reserve supply in his desk, cabinet or closet. In the hospital he should keep it in a locked drawer at the nurses' station, not on the desk in the dictation room. Hemostats and forceps should not be left in plain view but put out of sight or better still locked up.

The Drug Enforcement Agency number on blank prescription pads makes forgery easier for the addict. Ideally it would be best not to have this number preprinted on them but it is practical and time-saving.

Stealing prescription pads is relatively simple compared to the elaborate games addicts play to obtain narcotics. One ploy familiar to many physicians is the patient who complains of renal colic. In the process of providing a urine sample he intentionally pricks his finger and adds a few drops of blood, thus simulating hematuria. Combined with the feigned flank pain and other appropriate symptoms the physician may be tricked into administering a narcotic as well as providing a prescription for additional doses in another form. The physician knowledgeable of the characteristics and patterns of renal colic usually spots the patient faking the ailment, particularly if the physician is on guard against such tactics. Other symptoms and a variety of pains have been presented on occasion by patients wanting drugs. Narcotics are always requested.

Rather than fake an illness, the addict may approach the physician openly acknowledging his dependence upon a drug. Usually he reports that he is from out of town but on his way home to begin detoxification and rehabilitation. He requests just enough of the narcotic to get him to Ohio, Michigan or wherever. The addict who employs this tactic is not likely to exhibit typical withdrawal symptoms.

In dealing with these patients the tip-off comes not only from the characteristics of presenting symptoms and the way the act is carried out but in the request for a particular drug. Dilaudid appears to be the current favorite; resale of these tablets is quite profitable. The drug is requested after the patient has been informed that he is to be given another medication. He will insist upon Dilaudid and sometimes Percodan stating that other medications have not been helpful. He has tried them all.

All prescription pads kept in the examining room should be marked with "Not Valid for Schedule II Drugs." This would eliminate the problem of patients stealing the pads because they would not be able to get a prescription filled for the more harmful drugs and they would be of no value to anyone wishing to forge a prescription for the more popular drugs. All other Schedule II prescription pads could then be kept in the doctor's own personal desk drawer for his easy access only.

It is important that prescription pads be kept in hand or out of sight. There is a need for the physician to be wary of the patient who feigns pain and demands a specific narcotic drug.

● Dr. Smith, 1406 Kingsley Avenue, Orange Park 32073.

The hardest thing in the world to open is a closed mind.

A Simple Solution to "Legitimate Prescribing" of Street Drugs

Guy T. Selander, M.D.

Given the opportunity, I have always believed that physicians will "do right." Not by government edict or economic pressure, but by appeal to reason and common sense. The more than 800 physicians of Jacksonville, Florida have reinforced this belief. The leadership role of a medical organization implies not only the "honor and glory," but responsibilities. The officers and boards of directors of the Medical, Osteopathic and Pharmaceutical organizations of this community responded with responsibility when faced with the problem of "legitimate prescribing" of amphetamines and methaquaalones.

In May of 1977, during the early part of my tenure as president of the Duval County Medical Society, a headline splashed across the front page of the Jacksonville Journal: **Amphetamines: Six MDs Supply Them Here.** There followed a description by reporter Bruce Horovitz of large prescribing of these schedule II drugs by a handful of local physicians. When asked to respond, I flatly stated that amphetamines were **not** a problem in Jacksonville, and that in my opinion, this article represented sensationalism, obviously blown out of proportion. How wrong I was.

The next day, Cy Kothman, President of the Duval County Pharmaceutical Association, came to my office and "laid some numbers on me." In a three month period, more than a million doses of amphetamines were prescribed in the area of North Florida between Daytona Beach and the Georgia state line.

The Duval County Medical Society Board of Directors, in considering this problem, was first inclined to refer the involved physicians to the Florida State Board of Medical Examiners. Instead, the more difficult and more responsible decision was made to become involved, and to handle local matters locally, to clean up our own yard.

Prompted by these sobering statistics, a joint study group was formed. The group was comprised of representatives from the Duval County Medical Society, District II Florida Osteopathic Medical Association, the Duval County Pharmaceutical Association, and Jacksonville Health, Welfare and Bio-Environmental Department. Several meetings were held during which an evaluation was made of statistics of actual doses of amphetamines sold through two wholesalers in Jacksonville — broken down on a month by month basis. Louis J. Larmoyeaux Jr., D.O., President of District II Florida Osteopathic Medical Association, informed the members of that organization regarding the problem and enlisted their support in curbing the prescribing of amphetamines. Letters were sent to our Duval County Medical Society members known to prescribe these drugs heavily. The appeal was to their good sense ("stop prescribing or your name may appear in the paper") with immediate favorable response by most of the physicians involved. Communication with the Drug Enforcement Administration and the Florida State Board of Medical Examiners was made in the cases of a few physician holdouts.

The committee then studied a program carried out in northern Kentucky by physicians and pharmacists in which amphetamines were actually withdrawn from the pharmacy shelves. After careful consideration, a proposal for Duval County was formulated. As Medical Society president, I spoke to most of the specialty societies in Jacksonville, and enlisted their support. At every meeting there was 100% accord that we should move forward with the program.

Accordingly, the committee adopted the following policy statement:

> "There is no rational use for amphetamines in the treatment of obesity today. It is apparent that much of the amphetamines that are for sale on our school grounds have been obtained through legal prescriptions. Your board, therefore, urges the physicians of this community not to prescribe amphetamines for appetite suppression, and encourages a joint effort of the medical and osteopathic societies and the pharmaceutical association to have amphetamines withdrawn from the shelves of the pharmacies in Duval County. Furthermore, there will be the imposition of a 48 hour delay for legitimate prescriptions of these drugs (i.e., their use in narcolepsy and hyperactivity)."

It was pointed out to the physicians by the pharmacists that whenever amphetamines were prescribed, a companion prescription for methaquaalone was also often written. Since alternative

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hypnotic medication is available that does not have popularity with the drug culture, it was decided by the respective association governing boards to withdraw methaquaalones as well.

The news media in Jacksonville were very cooperative and patient during the five months that it took to compile data and formulate a suitable program. On October 14, 1977, a press conference was held, and a news release given by the organizations involved. An immediate news blitz was instituted: WAR DECLARED ON 'LEGAL' DRUGS was the headline, and the program was outlined to the public on page one. The following program was instituted on December 1, 1977:

1) Amphetamines and Methaquaalones were withdrawn from the shelves of all pharmacies in Duval County.

2) Imposition of a 48 hour delay in delivery of any methaquaalone or amphetamine prescription was instituted. Pharmacists were instructed to check the validity of each such prescription with the physician. This would allow sufficient time for the pharmacist to order the material to cover the valid prescription.

3) Physicians were furnished with a list of original package sizes of the drugs involved, and were instructed to prescribe only in the original package size when medical necessity warranted the use of either category of drug. The physician's prerogative was not usurped, and the procedure of ordering only the original package sizes eliminated the necessity of shelf stock in the pharmacy. Burglary and hold-ups should be markedly reduced.

4) The previous delay of 90 days allowed pharmacists to reduce their inventories, and allowed physicians to institute substitute therapy with those individuals who had become dependent on these agents.

Community response was immediate and extremely favorable. Some expressed surprise and even disbelief that this program was instituted voluntarily, and not by government edict. Editorial support by both newspapers was favorable, and local radio and T.V. coverage followed suit. There followed national television coverage on the NBC Today show and the CBS news.

The first full month of the implemented program showed a reduction in sales of amphetamines of **81%** compared with six months previously. The remaining 19% were primarily the dextroamphetamines used in the treatment of the hyperactive child and narcolepsy.

Methaquaalone sales were reduced 56% during the same period. In view of the prescription of these drugs in nursing homes, hospitals and rehabilitation centers, this reduction is considerable.

Word on the street is that the program has been very successful. While the federal government continues its hearings on amphetamines, our voluntary effort appears alive and well. The joint committee is still functioning, and is currently looking at Dilaudid, a drug that has recently gained widespread street usage in Florida.

If a lesson can be learned from our experiences in Duval County, it is that physicians, by becoming informed and involved, can become part of the solution instead of part of the problem.

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Note: The FMA Board of Directors has endorsed the DCMS program, and encouraged other component societies to "explore the feasibility of a similar program in their own local areas." (Recommendation No. 18, Report of the Board of Governors, Handbook of the House of Delegates.)

Obviously a quiet mind is essential to a rational approach to a problem. One cannot think efficiently when the mind is in a tumult of emotional reactions. The first principle of clear thinking is quiet thinking.

Dr. Norman Vincent Peale

Keeping Up

Wade S. Rizk, M.D.

Some time ago I received a Physician's Recognition Award from the American Medical Association for fulfilling the requirements in Continuing Medical Education (CME) for a three-year period. This also entitles me to maintain membership in the American College of Radiology which adopted this requirement at its annual meeting in 1974. This followed a 1973 resolution by the American Board of Medical Specialists adopting the policy that periodic recertification of medical specialists on a voluntary basis be implemented by its member boards. In 1974 this was further hardened by emphasizing mandatory reexamination as the modality for recertification. However, most boards have tread lightly on this issue and have opted, for the present, to accept CME programs rather than recertification by examination. Eventually, however, it seems probable that inexorably the policies of the ABMS will supervene, such is the peer pressure for recredentialing at a standard high level.

The FMA's requirements for CME credit are essentially the same as those of the AMA: 150 hours of credit in a three-year period with a minimum of 60 hours in Mandatory (Category I) Credit.

While Mandatory (FMA term) and Category I (AMA) are synonymous and in general pertain to the same subject matter there are exceptions, and hence the terms are not identical. Some programs that are not included under Category I are eligible for FMA Mandatory credit, when approved by the FMA Committee on Continuing Medical Education.

The Oregon Medical Association in 1970 was the first state medical organization to establish a mandatory continuing medical education requirement after licensure. But even prior to that, the first medical group to require mandatory CME for its members was the American Academy of General Practice which adopted this program in 1947. Twenty years later, in 1967, the concept of Continuing Medical Education was further reinforced when President Johnson's Commission on Medical Manpower noted in its report that one-time control in licensure of physicians was not enough, and stressed that the education of the physician "must be continued as long as he practices," with the further recommendation to explore the possibility of periodic relicensing of physicians, either by meeting acceptable CME requirements or recertification by examination. In 1971 the Department of Health, Education, and Welfare, in a special report on licensure of health personnel, arrived at the same conclusion and noted that primary licensure was a "less effective guarantee . . . against the growing problem of professional obsolescence."

The handwriting on the wall was unmistakable. It was an idea whose time had arrived and as Victor Hugo commented over 100 years ago, "Nothing can withstand the force of an idea whose time has come."

A compulsory CME program was adopted by the FMA on May 6, 1972 when the House of Delegates acted upon the recommendation of the Council on Scientific Activities. However, the requirements and provisions of CME underwent several modifications and revisions and finally went into effect in February 1976. Accreditation for an organization for CME is accomplished when it is accredited for CME by the Council on Medical Education of the AMA. The latest tabulation of organizations in Florida accredited for CME, as published in the August 15, 1977 issue of JAMA supplement, lists 22 organizations.

The philosophy underlying these postgraduate requirements in medical education is obvious. They are devised to keep the practicing physician competent and abreast of new developments for providing optimal patient care. The biomedical sciences in all categories have undergone revolutionary changes in the past two decades with the formulation of new concepts. A medical degree and state licensure do not vest an individual with knowledge of these new developments, constantly generated by new findings and research. Any physician worth his salt soon learns that he must be a perpetual student to keep up with this vast proliferation of scientific data. This impetus and urge for CME are not only to acquire new knowledge but also to regain useful information lost over time by the process of forgetting.

It becomes at once apparent that much of the knowledge I learned in medical school in those halcyon days of long ago is obsolete and inaccurate. Even my residency training was relatively simplistic and narrowly confined in the face of the vast complex and sophisticated modalities and interpretations now available in my specialty. This explosion and tumult of new knowledge has occurred in all disciplines of the biomedical fields.

CME Methods

Continuing Medical Education, although not new, is a major activity of the present generation of physicians and its development into a substantial industry is an impressive undertaking of our age. The methods used are both old and new. One of the oldest, most available, and most productive is reading. There is a profusion of reading material in journals, abstracts, and books. One has to exercise selective judgment as to how much of this material can be apportioned into a busy schedule. The avalanche of information available to us in English alone is so prodigious that we cannot attack but a small segment of this material that stacks up on our desks.

Another very effective method of self-education is the reference route, which most of us use daily. This is in response to a specific case problem in our practice that sends us back to reference works to gain a fuller understanding of various aspects of the problem confronting us. The information thus gained has the added advantage of immediate relevancy for a firmer foothold in one's memory bank. Other methods which are time-honored and effective are group meetings, staff conferences, consultations, participation in hospital committees and county and state committees. The out-of-town medical meeting, either sectional or national, deserves special comment. It is a valuable adjunct to learning since one has an opportunity to see and hear experienced and proficient teachers in a particular field. This also affords an opportunity to discuss mutual problems with colleagues or provides ready information for obtaining answers to bothersome questions from experts. Another spin-off benefit is the opportunity meetings provide for social intercourse and recreation. I started to include rest among the enumerated benefits but I don't think the average physician gets much rest at these meetings. The weekend symposia, in particular, are rather hectic but they are also especially remunerative since a considerable volume of information can be conveyed in a concentrated period of time before attention begins to lag, and without disrupting one's practice. There is a wide range of effectiveness of teachers in postgraduate education. Some, although highly qualified, are somewhat disorganized in their presentations and seem less effective in putting their material across. These, however, soon lose their popularity on "the circuit" and are eventually dropped. Most, through the process of culling, soon earn a reputation for excellent transmission of information in an orderly efficient manner. Their talks are often sparkling and witty and the slide material well organized and readable when projected on the screen. Ennui and satiety are relieved by epigrams and histrionic embellishment and occasional humorous stories, some ribald. The after-presentation question and answer period often sheds important sidelights that lend extra dimension for a fuller comprehension of the subject.

The tax-deductible feature of attending a course of postgraduate instruction in a distant city is an added incentive. In fact, the IRS may be said to play a vital role in encouraging CME with the incentive of tax deduction.

Some of the newer methods of dissemination of teaching materials include self-instructional packages arriving by mail each week or month, audiotape cassettes, audiovisual educational programs with cassette-slide sound and videotapes in high energy video cassettes requiring a player and TV receiver. The latter entails a substantial outlay and for that reason has not captured as many takers as its sponsors had hoped. However, I find it a very enticing way to learn and the subject matter is attractively organized with a clear television picture rendering the service as good or better than actual attendance at a course. It also has the added advantage of repeat viewings. Another advantage is the use of the equipment for nonprofessional purposes as, for instance, taping a TV program even in absentia. Since time is "of the essence," the audiotape cassettes allow one to listen to recordings of excellent teachers on the subjects of your choice while traveling in your car from home to office, between hospitals, or on out-of-town trips when you tire of listening to junk music.

The self-instructional package is another excellent learning method. This includes a testing service for computerized CME credit.

If one must find fault with some courses and syllabi, two minor faults should be mentioned. One is an occasional extended discussion and preoccupation with some rare medical entity that one is not likely to encounter in a lifetime of practice but is of academic interest only. It is not that these subjects should be ignored but rather in the interest of time they should be briefly mentioned, placed in their proper category, and disposed of. The other time-waster is inordinate and meticulous detailed study of some project in basic research which I find, in many instances, to be irrelevant. Should I have occasion to study this aspect of the problem, I could pursue the matter on my own.

But having said that, let me at once remark that medical postgraduate education in the United States is generally excellent and of a high order. Many of the weekly and week-end courses have a faithful following, the devotees of whom return year after year to imbibe new knowledge and concepts from experts.

Besides, the almost daily announcements that the mail brings on CME, JAMA publishes an annual supplement that tabulates all the approved courses in each specialty. This concern with opsimathy is taxing but intellectually stimulating. It is an adventure not only into new highways and byways but it is seeing old grounds

with new vision and peering into nooks and crannies not previously perceived or forgotten.

Conclusion

In conclusion, let me state again that CME is an integral part of a physician's daily routine and that the opportunities for keeping up are vast and effective. The limiting factor is time. Snippets of time have to be apportioned to the various activities clamoring for our attention and support whether it be professional, family, social and community or recreation. Physicians as a highly educated group do not view life, to borrow Robert Frost's phrase, as a diminishing thing. Even though we choose to be confined to a specific scientific discipline, our interests range far and wide. We are involved with all of life and venture into the humanities — music, literature, the arts, including painting, sculpture, photography, theatre, etc., besides sports, some of which become serious hobbies. This requires energy, concentration — and time. It has been said that time is the greatest of all tyrants. There is no way that we can satisfy all the demands made on our time. One must guard against undue zealotry — a well-meaning but tyrannical adherence to a rigid schedule. You are defeated from the start because it is impossible to satisfy an insatiable program of coverage if your goals are unreasonably high. Hippocrates, in his famous "Aphorisms," alludes to the brevity of the human experience and the vicissitudes of learning, "Life is short, and the art long; the occasion fleeting; experience fallacious, and judgment difficult."

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At Day's End

If you sit down at set of sun
And count the acts that you have done,
And, counting, find
One self-denying deed, one word
That eased the heart of him who heard —
One glance most kind,
That fell like sunshine where it went —
Then you may count that day well spent.

But if through all the livelong day,
You've cheered no heart, by yea or nay —
If through it all
You've nothing done that you can trace
That brought the sunshine to one face —
No act most small
That helped some soul and nothing cost —
Then count that day as worse than lost.

—George Eliot (1819-1880)

Regionalization

R. Edward Dodge Jr., M.D.

Regional administration is designed to improve horizontal and vertical articulation and integration of services, communications and support. It also is considered as decentralization, bringing decision making closer to the people and thereby making government more responsive to local needs. What appears to be admirable in design, however, often has proven less admirable in practice.

Problems of Regionalization

There are two principal alternatives in building a regional framework. Regional offices may be given a largely consultative role to the local level, in which case their authority and decision-making responsibility tend to be weak, or they may be given a strong degree of sovereignty. A middle ground also is possible though seldom achieved.

In the weak regional structure there is danger of immobilizing the local level because of paralysis in the decision-making process. The focus for responsibility is not clearly defined. Nobody seems to know whether decisions are made at the regional or at the state level. Decision-passing, which is always a danger in any governmental office, becomes almost inevitable in a weak regional structure.

A strong regional structure is probably less common than the weak structure. It has dangers, principally the likelihood of emasculating local level offices. Weakening of local level decision-making ability will be directly proportional to the strength and efficiency of the regional office. A weak local office will be less capable of adjusting and evolving to meet the needs of the locality; it will be constrained by regional priorities. Regional personnel will be more interested and concerned in programs at the regional level than at the local levels, interest in the latter inevitably being secondary. In short, a strong regional structure may bring more efficient services to the local level, but it will reduce local flexibility, paradoxically weaken local capability, and be less responsive to local needs which do not fit into the regional scheme.

Whether regional offices are strong or weak, vertical communication difficulties are likely to increase. A regional office should be a channel through which communications flow easily in either direction. In practice, however, the added level it represents acts as a filter, slowing communication or blocking it altogether. Loss of the free and easy flow of information eventually leads to misconceptions, misinformation and detrimental effects on all programs.

A major theoretical and practical problem in the regional structure is that the regional office is caught in the middle of conflicting duties. The regional office is an advocate and supporter of local level offices but also an apologist and implementer of top level policy. Thus, it is caught in a schizophrenic position which may account for the paresis often displayed by regional type offices. This same conflicting bind also gives rise to another odious side effect. The regional office may absorb much of the static from the local level about programs which are not working out well but may shield the top level from such static either consciously or unconsciously. Such shielding gives rise to the misconception that programs are working out smoothly when, in fact, they are not. The effects on planning and programming can be disastrous.

The regional structure seems to promote planning and decision-making from the top down. Grant has cautioned against this danger[1] but it appears to be an almost irresistible occurrence.

Any regional set-up inevitably has a buffering effect, keeping problems and consequences of bad decisions from having the sharp impact which they should have on the top level. In addition, there is a strong tendency to equate decision-making capability with the level in which a person works; the higher the level the more capable the officials are presumed to be. There is some basis for this presumption as well as some fallacy. In any event, the net effect of high level decision-making combined with intermediate level buffering is to create an administrative recipe for poor decisions and poor programming. The top level makes decisions based upon intelligence not of facts as they are at the local level, but on facts as they are interpreted and buffered through the regional level. The difference is critical and has contributed to major disasters in American domestic and foreign affairs. Halberstam presents strong evidence that buffered intelligence led to many of the bad decisions in the Vietnam debacle.[2]

Obviously Florida's health system is in no sense analogous to the Vietnam war; nevertheless, the dangers

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of decisions based upon buffered intelligence are the same.

The matter of relationship of decision-making capability to level of office is not clear cut. To the extent that top level decision-makers are more experienced, better trained and have wider access to factual information, they are indeed more capable. On the other hand, there are experienced, well-trained people at local levels who are capable of good decision-making. Local decision-making often may be sounder than decision-making at the top, particularly if the latter is based upon information processed through a regional buffering system.

History shows that poor decision-makers exist at every level of government. Furthermore, even the very best and brilliant administrators are capable of bad decisions. In short, no level of government can guarantee to produce better or more effective decision-making than another. The only consistent relationship between level and decision-making is that the higher the level the more people will be affected. Thus, a bad decision at the local level is felt only at the local level while a bad decision at the regional level affects many local levels. A bad decision at the state or national levels affects the lives of millions of people. There is, therefore, a clear obligation upon decision-makers to have as clear an understanding of all the facts as possible, as well as a clear concept of the consequences flowing from their decisions. This obligation becomes heavier the higher the position. The device utilized by many administrators, to simply postpone or avoid making decisions, is in itself tantamount to bad decision-making and is paralyzing to effective government.

In summation then, Grant's emphasis on the necessity of local input in planning and decision-making is absolutely necessary for good government.[1] The problem with a regional structure is that it actually provides structural obstacles to effective local input into decision making at the top level as well as buffering the quality of information available.

A regional level of administrative offices adds to the cost of administrative overhead for programs at the local level. If, in fact, regional offices improved communications, efficiency and decision-making processes, the added costs might be justifiable or might be made up by improved efficiency. However, results elsewhere do not give much basis for optimism. When one takes into consideration the serious possibility that communication, coordination, and efficiency of services may actually deteriorate in a regional structure, the prospect of the added administrative costs becomes especially abhorrent.

Practical Aspects of Regionalization

When all the pros and cons of regionalization are examined, the most pertinent question remains: How has the concept actually worked out in practice? There is a program in the United States in which comprehensive curative and preventive health care has been organized in a regional structure. The model has been in operation since 1955. It is the Indian Health Service, a branch of the U.S. Public Health Service, which generally has been rather highly regarded for its innovations in governmental health care.

A book written in 1971, "Federal Health Care (With Reservations!)," by Robert L. and Rosalie A. Kane, explores many aspects of the Indian Health Service and makes suggestions as to what could be done to improve it. Perhaps the most striking suggestion is that area offices (regional level offices) be abolished. The authors document hindrances posed by area offices and state that abolition not only would clear up such hindrances but would also invigorate the entire Indian Health Service at the Service Unit level.[3] In short, they seek many of the benefits which Florida gave up as it went to a regional structure.

Conclusions

Reasons why regionalization of Department of Health and Rehabilitative Services activities is a mistake for Florida have been explored. An example is presented of a prominent health care structure in which it has been recommended that the regional tier be removed because of the problems which it generates or aggravates.

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Think like a man of action, act like a man of thought.

Henri Bergson

Health Professions Education in the State University System

Patricia Cockrell Barrett

Abstract: The State of Florida through the State University System (SUS) provides a wide variety of educational programs in the health professions field. Included in these programs are undergraduate and graduate medical education, dental education, veterinary medical education, nursing and pharmacy education, and health related professions education such as radiation therapy, speech pathology and audiology, and physical therapy. Student enrollment in these programs, located at all nine universities in the SUS, exceeded 5,000 in Spring, 1977. In addition to programs in the SUS, educational opportunities are supported by state funds at the University of Miami and through the Southern Regional Education Board (SREB). The adequacy of health professions education in terms of diversity, providing health care practitioners, and availability of the programs to individuals is considered.

Florida, with its high in-migration rate, has benefited from health care practitioners educated in other states, both older individuals who practice part-time and young recent graduates who practice a lifetime. However, the state cannot rely only on the in-migration of health professionals. The State University System (SUS) has assumed the responsibility of providing education to meet the state's need for health care professionals and for educational opportunities in health care fields for its citizens. Many programs are available at the various public universities within the state. Other opportunities are available through the Southern Regional Education Board (SREB), a regional cooperative program which provides educational opportunities for Florida residents in other southern states. The SUS contracts with SREB to reserve a specified number of positions for Florida residents and coordinates the program by providing information to students and certifying applicants as Florida residents. The university selects among the certified applicants, receives a stipend from the SUS, and charges the student in-state tuition. Additional health education programs are, of course, located in private institutions and community colleges. Those health related educational opportunities available through the SUS are best characterized by their variety and diversity.

Medical Education. Within the SUS there are two medical schools, the University of Florida established in the late 1950's and the University of South Florida established in 1971. The former has a four-year curriculum and the latter a three-year. Additionally, the University of Miami, a private institution, receives state support as Florida's first accredited medical school for MD students and for an innovative program in which an individual with a PhD can earn a MD in an accelerated course of study. Through SREB Florida residents may apply for several contract positions at Meharry Medical College in Nashville. These programs combined have an enrollment of approximately 1,200, graduating more than 300 MDs per year.

PIMS, the Program in Medical Sciences, at FSU and FAMU provides a unique route to admission to medical school with the objective of selecting students who are thought to be more likely to choose primary practice in a rural, small town, or inner-city area. PIMS consists of a series of courses, seminars, tutorials, and an advisory and selection system in conjunction with the basic science programs in the College of Arts and Sciences at both institutions. Participants move into the course of study at the beginning of their junior year and may transfer to the University of Florida or another medical school upon completion of their fourth, fifth, or sixth undergraduate year of study depending upon their background and progress. PIMS is equivalent in objectives but not in content or structure to the first year of the medical program at the University of Florida. The students enter the second year, Clinical Clerkships, upon successful completion of the FSU-FAMU program.

Beyond the MD degree, graduate medical education, internship and residency training are provided for through the Shands Teaching Hospital, Gainesville; Medical Center Affiliated Hospitals, Tampa; Jacksonville and Pensacola Education Programs, and the Community Hospital Education Program designed to aid in the training of general, first contact physicians in community hospitals throughout the state. Residencies are also available at the University of Miami and hospitals not affiliated with the SUS.

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Beginning fall, 1978, three places per year will be available for Florida residents at West Virginia School of Osteopathic Medicine through SREB. Currently osteopathic residencies are available in the Community Hospital Education Program.

Dental Education. The University of Florida College of Dentistry graduated its first class of 24 in 1975-76. Dental students pursue the first year of studies in basic sciences with first year medical students and then may complete their dental studies at their own pace through the use of learning modules with some graduating in less than the usual four years. The entering class size will be 80 when the school has reached its full development. Additionally, through SREB, Florida has supported contract places at Emory, Virginia, and Maryland. Total dental enrollment at UF and through SREB is approximately 300. Dental Auxiliaries which include hygienists, assistants, and laboratory technicians who provide support for dentists and increase the quantity of care which can be provided are trained in various junior and community colleges throughout the state.

Veterinary Medicine Education. The University of Florida College of Veterinary Medicine is the most recently established health related educational program in the SUS. An entering class of 40 began the program last fall, and the first full class of 80 which includes 15 SREB students from other states entered this fall. The Veterinary Medicine Teaching Hospital and Clinics, which provide clinical animal care for teaching purposes, opened this summer.

Nursing Education. Nursing education encompasses several types of educational programs which prepare individuals for different levels and kinds of health care delivery. Nurses providing care in secondary settings, characterized by patients who are experiencing acute or chronic illnesses that are common and well defined, are educated in diploma or associate degree programs. Florida has 22 associate degree programs in the Community College System and one diploma program at Jackson Memorial Hospital in Miami. Nurses who not only provide care in secondary settings but who also need the knowledge and skills to perform relatively independent assessment of the normal individual, to treat patients experiencing minor or nonrestrictive pathology or to make judgments which are less predictable in terms of outcome, are educated at the baccalaureate level. There are currently nine baccalaureate degree programs in Florida, two in private institutions and seven in state supported programs which include USF, UF, FAMU, FSU, FIU, UNF, and a cooperative program with FAMU at UWF. The total enrollment in state supported programs on a full-time-equivalent basis exceeded 800 in fall, 1976. Graduate nursing education — a master's program — at UF had an enrollment of approximately 40 in fall, 1976. As a result of the SUS Nursing Program Review, the Regents recommended that the present program at FIU be phased out, that FAU and FIU discuss a plan for a shared BSN program, that UWF seek an alternative to the cooperative program with FAMU, that the SUS contract with the University of Miami for master's nursing education, that doctoral education be arranged through SREB, and that other measures be pursued to strengthen nursing programs in the SUS.

Pharmacy Education. Two institutions, FAMU and UF, provide pharmaceutical education not only for individuals seeking their degree but also for practicing pharmacists who must pursue continuing education in order to maintain licensure. Undergraduate enrollment at the two schools totaled approximately 250 full-time-equivalents last year with additional students in the master's and doctoral programs.

Health Related Professions. Included under this label are a myriad of practitioners who provide very specialized types of health care and health related services. The programs in the SUS include: Occupational Therapy, Physical Therapy, Medical Technology, Medical Records Administration, Hospital and Health Care Administration, Speech Pathology and Audiology, Gerontology, Physicians' Assistant, Radiologic Technology, and Respiratory Therapy. These programs are located within various universities with a total head count enrollment last year of more than 1,500 students. Graduate education is also available in several of these fields. Through SREB there are 80 Florida residents attending optometry school at Southern College in Memphis and at the University of Houston.

Table 1 identifies the location, level of degree program, and spring, 1977 head count enrollment in the SUS health professions programs. Several programs, notably speech pathology and audiology and dietetics, are not classified by a particular university as a health related program, generally due to curriculum emphasis. As a result, there are additional programs at other universities not included in Table 1.

Is the SUS providing adequate health related education opportunities? In terms of diversity of programs available, either within the state or through SREB, we offer all health fields with a few exceptions, for example, public health and podiatry. Many programs are available at more than one institution within the SUS and several, for example nursing, are available at the majority.

In terms of providing health care practitioners, we can compare Florida to other states bearing in mind that a number of health care practitioners in the state have been gained by in-migration rather than by educational

Table 1 — Health Professions, Headcount Enrollment By Institutions and Degree Programs, Spring, 1977.

	Degree Program	Students
FAMU		
Nursing	B	222
Pharmacy	BM	291
Speech Pathology and Audiology	B	18
Total		531
FAU		
Hospital & Health Care Administration	B	102
FIU		
Health Science	B	169
Hospital & Health Care Administration	M	58
Nursing	B	260
Occupational Therapy	B	39
Physical Therapy	B	58
Medical Lab Technology	B	54
Total		638
FSU		
Nursing	B	498
Speech Pathology and Audiology	BMD	170
Medical Lab Technology	B	71
PIMS		79
Total		818
FTU		
Medical Records Administration	B	86
Speech Pathology and Audiology	B	64
Medical Lab Technology	B	89
Radiologic Technology	B	21
Respiratory Therapy	B	130
Total		390
UF		
Health Science	B	30
Hospital & Health Care Administration	M	27
Nursing	BM	292
Dentistry	P	180
Medicine	B[1] P	422
Occupational Therapy	BM	131
Pharmacy	BMD	461
Physical Therapy	B	192
Veterinary Medicine	M P	40
Medical Lab Technology	B	102
Total		1,877
UNF		
Nursing	B	154
USF		
Nursing	B	133
Medicine	P	214
Medical Lab Technology	B	197
Total		544
UWF		
Nursing	B[2]	86
Medical Lab Technology	B	43
Total		129
SUS		
Total		5,183

Data Sources: Spring 1977 Student Data Course Files
State University System Academic Programs Degree Inventory

B — Bachelor's
M — Master's
D — Doctorate
P — Professional

[1] Physicians Assistant Program students not included in this count.

[2] In cooperation with FAMU.

programs within the state. Several examples indicate that Florida compares favorably to the U.S. as a whole:

1. Florida has 171 physicians per 100,000 population as compared to a national average of 168 per 100,000 population (1977).[1]

2. Florida has 13.7 eye care practitioners (optometrists and ophthalmologists) per 100,000 population as compared to a national average of 14 per 100,000 population (1974).[2]

3. Florida had 40 active civilian dentists per 100,000 population as compared to a national average of 48 per 100,000 population in 1973, prior to the opening of our College of Dentistry.[3]

It should be noted that there is a long lead time between the decision to begin a particular program and a significant impact of its graduates on the manpower pool. For example, the College of Veterinary Medicine received planning money in 1969-70 but does not graduate its first class of 40 until 1980. These statistics, of course, do not address the question of distribution of health care practitioners within the state but there is no evidence that merely increasing the number of health care practitioners will solve the distribution problem.

In terms of availability of the programs to individuals, there are many instances in which an individual does not gain acceptance to the program which he or she desires. Of course, Florida is not unique in this respect as is evidenced by the number of U.S. citizens attending foreign medical schools. In several instances the number of applicants to a program is more than twice the number that can be accepted. Health

professions programs are providing educational opportunities for many students of all races. Data analyzed from spring 1977 Student Data Course Files indicates that approximately 5,000 head count students are enrolled in health professions programs in the SUS. An additional 1,500 identify their major as a health field but are not enrolled in a health professions degree program at the present time. Included in this 1,500 students, for example, are those undergraduates who identify themselves as pre-med, pre-dental, or pre-vet.

Education in the health related fields is costly. Over the past ten years, the annual budgets for medical and health related programs have grown significantly. The budgets for these programs now approach 20% of all General Revenue Appropriations to the SUS. By comparison, the enrollment in these programs is less than 5% of the total SUS enrollment. SUS Cost Study data indicates that where costs can be compared, credit hour instruction in the health professions is approximately twice the average for all disciplines for upper level undergraduate instruction.[4] Increasing health professions education, given a relatively fixed total budget for the SUS, decreases the funds available for other programs by a greater percentage.

Health care practitioners are a valuable resource to the state, but the decision to increase educational opportunities in these fields must be given careful consideration. Not only the cost but also the long lead time between planning and impacting the manpower pool must be considered. At the same time, it should not be forgotten that Florida is an in-migration state and will continue to benefit from individuals educated elsewhere. We must plan well not only to provide well qualified health care practitioners for the state but also to give our citizens the opportunity to become health care practitioners.

● Ms. Barrett, 107 West Gaines Street, Tallahassee 32304.

References

1. Medical Economics, July 11, 1977, p. 242.
2. Health Resources Statistics, 1975, pp. 175 and 227; Statistical Abstract of the U.S., 1976, p. 11.
3. Health Resources Statistics, 1975, p. 81.
4. 1975-76 Expenditure Analysis, State University System, Educational and General.

A Straight Course

One ship drives East and another drives West
With the selfsame winds that blow.
'Tis the set of the sails
And not the gales
Which tell us the way to go.
Like the winds of the sea are the winds of fate,
As we voyage along through life;
'Tis the set of a soul
That decides its goal
And not the calm or the strife.

Ella Wheeler Wilcox

NORTH FLORIDA REGIONAL HOSPITAL
and
THE NORTH FLORIDA REGIONAL MEDICAL FOUNDATION
announce
THE FIFTH ANNUAL CARDIOVASCULAR SYMPOSIUM
September 14-15, 1978

The HILTON INN — Gainesville, Florida

Director: Howard W. Ramsey, M.D.
Co-Directors: Luis J. Cintado, M.D.
Thomas D. Bartley, M.D.

This fifth annual symposium is devoted primarily to a review and reappraisal of past and current concepts of diagnosis and treatment of coronary artery disease. A full and exhaustive review of recent data comparing medical and surgical therapy of patients with angina will be presented. Other topics to be discussed include bacterial endocarditis, the myocardiopathies and the current status of cardiac transplants.

A special section of the program, to be presented by Mr. Melvin Belli, will be devoted to an analysis and discussion of current medical-legal problems including the proliferation of malpractice suits.

An outstanding faculty has been assembled for the symposium and the program should be of interest to all physicians involved in the care of patients with cardiovascular problems.

FACULTY

Ralph Alley, M.D.
Christiaan Barnard, M.D.
Melvin Belli, Lawyer
Donald Effler, M.D.
Peter Gazes, M.D.
Goffredo Gensini, M.D.
J. Willis Hurst, M.D.
W. Dudley Johnson, M.D.
Arthur Mauceri, M.D.
Richard O. Russell Jr., M.D.
Earl K. Shirey, M.D.
Douglas R. Shanklin, M.D.
W. Jape Taylor, M.D.

As an organization accredited for continuing medical education, the Medical Education Committee of the Florida Medical Foundation certifies that this continuing medical education activity meets the criteria for 14 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. The medico-legal portion of the program is acceptable for 3 credit hours in Category 2. Approval for 18 hours Prescribed CE credit has been requested from the Florida Academy of Family Physicians, the Florida Board of Pharmacy and the American Society of Radiologic Technologists.

HOTEL RESERVATIONS: A block of rooms has been reserved at the Hilton Inn for symposium participants and reservations can be made through your local Hilton Inn, the Hilton Reservation Service (toll free number listed in your local telephone directory) or by calling the Gainesville Hilton Inn directly (904) 377-4000.

RESERVATION FEES: $175. - all physicians
50. - paramedical personnel (nurses, technicians, etc.)

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For further information, call: Dr. Howard Ramsey or Hazel Sessions (A.C. 904) 377-8511, extension 195.

EDITORIALS

Your Own Personal Myocardial Infarction

Frank E. Adel, M.D.

This is a relatively unscientific article based on a series of only one case, and I don't doubt that some may question the credibility of the author and the article; however, on the other hand, my own recent experiences and observations of the past few months may help someone, I hope. It is in this spirit that I dedicate this article to anyone who is so helped.

SURPRISE, you are having an M.I.! In our innermost heart of hearts, we all fear this eventuality. Why not, we're all human, and it does happen to many physicians too. The theme of this article is that while it can happen to any of us, it may not be all that bad, it may not even be painful, and the end result may only be an inconvenient, though interesting experience.

In December 1977, I awoke one Sunday morning after a previous uneventful day and night of sleep, with no unusual stress or trauma, and no indiscretions. In other words, there was nothing with a woman in a motel or an alcoholic debauch. I was nauseated, ached all over, had chills and fever, a scratchy throat and a hacking cough with some mild burning high in the substernal area, accentuated by deep inspiration and changing positions. I considered the pain to be pleural in nature. "Flu" was prevalent, and that was what I thought I had. My wife had just recovered from about the same set of symptoms one week earlier. I stayed home and in bed for three days, drank cups of chicken soup, plus a lot of other fluids (nonalcoholic), and was surprised when I didn't improve as rapidly as I usually have about once a year under similar circumstances. I continued to have chills with profuse sweats and felt weak. The next day chest x-rays were normal, but my physician friends suspected a myocardial infarction which was confirmed by an electrocardiogram, although I did keep wondering (and hoping) if this were not a viral pericarditis secondary to the "flu." I walked out to my car and had my wife drive me to the hospital. From the Emergency Room I was admitted directly to the C.I.C.U. I really wouldn't know or completely accept the diagnosis of M.I. except for the serial cardiograms and the serum enzymes, even though I have the greatest confidence and respect for my cardiologists.

The moral of this tale is: The fear of a heart attack and its disparities is much worse than having an M.I. I was reminded that the patient with an M.I. may have little if any pain, or no pain at all, and may not require narcotics or feel sick. While this is certainly no joyous event, neither should you fear that it will be a catastrophic episode either. The most frightening things are the ECGs and the abnormal tracings and laboratory data. The C.I.C.U. where I stayed was comfortable, cheerful, very competently staffed around the clock, and I was well attended. The weaning rooms were very comfortable and contained all reasonable conveniences. The prospects of my family becoming unglued emotionally was an immediate concern but this did not happen, and, looking back on the whole episode I found it to be a rewarding and interesting experience.

The worst part of my illness was the frequent venipunctures, even though they were done most expertly and with great consideration. The recovery period had some boring hours, but I found that I could spend the time well filling out insurance forms and doing other paper work.

The message I wish to convey to all of you hard working guys and gals who may be fearful that some day the "ax may fall," is that it can well be 1000% less traumatic and disabling than you may believe, and a whole lot better scene than many other diseases that you see so frequently.

Even though my final diagnosis was "massive anterior infarction," I feel very blessed for the easy time I had, giving credit first to Almighty God and His mercy, and also to my wonderful cardiologists, and the excellent

staff who attended to me so faithfully and so well in the hospital.

My parents taught me that out of every adversity some good does come. In my recent illness I not only found out some things about how the medical care system really works, but I also found out something about how I stand with my God, the strength of my family, who my friends really are, and something about my insurance program. On returning to work on February 17, 1978, I found myself to be a better physician.

So, be of good cheer and fear not. Fear itself may well be more disabling than the arterial occlusion. I pray that those of you who are destined to face the same trial as mine, if it turns out the same way, will feel as grateful about the outcome as I.

I report this case because it may be of some help in allaying fears that some of you may have. I assure you that I remember my last hospitalization in the mid-thirties for a T&A as being much worse. If the "silent M.I." can happen to me, it can also happen to others, as is well documented. So, if you suddenly find out you are having an M.I., don't let it throw you, the odds are in your favor and the whole thing could be a virtual "cake-walk."

In conclusion, please let no one misunderstand my meaning . . . Of course, the acute M.I. is a dangerous thing and fraught with potential complications, and needs proper attention and management. What I am saying is that the symptoms and management can be minimal or practically negligible with a surprisingly good recovery; therefore, should the fateful day arrive for you, it is very possible that you will be able to look back at the whole thing and say, "Gee, this was no more inconvenient than an appendectomy or a fractured tibia." My best advice is: Don't lose your religion or your cool, be a good PATIENT, and think positively. God bless.

• Dr. Adel, P. O. Box 1149, Lake City 32055.

Preliminary Announcement

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF INTERNAL MEDICINE

"SELECTED TUTORIALS IN INTERNAL MEDICINE"

The Department of Internal Medicine is initiating a series of tutorials in all fields of Internal Medicine designed primarily for physicians who wish to have an in-depth review of specific topics with emphasis on current developments and their practical clinical applications. Each course will be limited to five physicians thereby allowing for close faculty-registrant relationship. The duration of the courses will vary from one to four weeks depending on the subject and the particular needs of the enrolled physician.

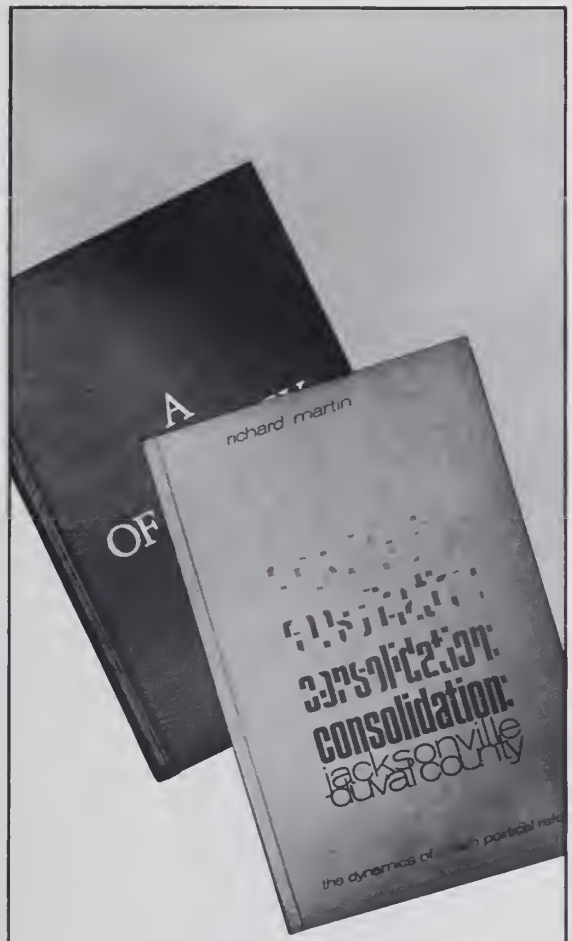
Formal lectures, clinical rounds, laboratory techniques, audio-visual aids, self assessment examinations and printed materials will be carefully selected.

Postgraduate credits will be identified by appropriate certificates.

The following are examples of the tutorials to be offered:

- CRITICAL CARE IN INTERNAL MEDICINE
- NON INVASIVE DIAGNOSTIC TECHNIQUES IN CARDIOLOGY
- CLINICAL CARDIOLOGY
- ELECTROLYTE AND ACID-BASE DISORDERS
- DIABETES MELLITUS
- HUMAN GENETICS
- ELECTROCARDIOGRAPHY AND CARDIAC ARRHYTHMIAS
- BEDSIDE HEMODYNAMIC MONITORING AND CARDIAC CLINICAL PHARMACOLOGY
- **OTHER SUBJECTS UPON REQUEST**

For additional information write or call: J. Bocles, M.D.
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Department of Internal Medicine
1150 N.W. 14 Street, Miami, Florida 33136
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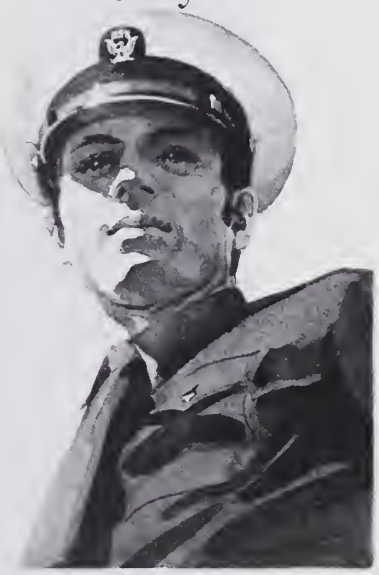
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ORGANIZATION



O. William Davenport, M.D.

Oliver William Davenport, M.D., President Florida Medical Association

It is fortunate for organized medicine in Florida that Oliver William Davenport (Bill) came to Miami for residency training in Obstetrics and Gynecology in 1956. Bill and his new bride, Carolyn Hughes, were instantly adopted as Miami's own and have been active politically, socially and professionally ever since.

Bill is a natural leader. He has been president of every organization to which he has belonged — including the student body at the University of Arkansas School of Medicine from which he graduated in 1952. Since becoming a founding member of the Student American Medical Association and serving on its first Board of Directors in 1949 and 1950, Bill has been an active participant in organized medicine and a defender of its principles.

He understands the complexities and organization of Florida medicine very well, having served as President of the Dade County Medical Association and holding numerous other offices in that organization. He has also served the Florida Medical Association as its Vice President, Chairman of the Council for Scientific Activities, and Chairman of the Public Relations Committee.

A Clinical Associate Professor at the University of Miami School of Medicine and active in group practice of Obstetrics and Gynecology in Miami since 1958, Bill is also well informed as to the needs of all physicians who practice medicine in Florida.

Bill and Carolyn's only child, William, will enter medical school in Florida next year. William's motivation and goals have been greatly influenced by his father's example in the practice of medicine.

An avid outdoorsman, armed with the charming good looks of Clark Gable, and the commanding voice of a statesman, Bill has instant credibility and acceptance into any group in which he may participate. He is a good listener, always approachable, and will try to make the best decision. His frankness is refreshing and he is governed by a strong sense of honor. You can be sure Bill's principles will never be compromised or sacrificed in the search for the resolution to problems that face us in the practice of medicine today. I have known Bill for over 20 years and it is a pleasure to see him take his place among the outstanding leaders of Florida medicine. We are fortunate to have his leadership. May his energy, health and wisdom be sustained and augmented by our never faltering support.

J. Lee Dockery, M.D.
Gainesville

Self respect cannot be hunted. It cannot be purchased. It is never for sale. It comes to us when we are alone, in quiet moments, in quiet places, when we suddenly realize that knowing the good, we have done it; knowing the beautiful, we have served it; knowing the truth, we have spoken it.

—A. Whitney Griswold



William Brown Deal, M.D.
New University of Florida Medical Dean

Dr. Deal Is Named Vice President and Dean At University of Florida

William Brown Deal, M.D., who less than a decade ago was Chief Resident in Medicine at the University of Florida, is the University's new Vice President for Health Affairs and Dean of the College of Medicine.

Dr. Deal's appointment was announced by University President Robert Q. Marston, M.D., on April 25, 11 months to the day after the death of Vice President and Dean Chandler A. Stetson, M.D. (See JFMA July 1977, pp. 494-496).

Dr. Deal, 41, served under Dr. Stetson as Associate Dean, and since his death has functioned as Acting Dean. His appointment to the dual positions of Vice President and Dean climaxed a long nationwide search for a successor to Dr. Stetson.

A native of Durham, N.C., Dr. Deal received his A.B. degree from the University of North Carolina in 1958 and stayed on to earn his M.D. in June 1963. He came to Florida that year for an internship at the University of Florida's Shands Teaching Hospital. He remained at Shands for residency training and a fellowship in infectious diseases, and in 1969 he was appointed Chief Resident in Medicine.

In addition to his administrative posts, Dr. Deal serves as Professor of Medicine in the Division of Infectious Diseases and in the Department of Community Health and Family Medicine.

The new Vice-President and Dean served in the Medical Corps of the U.S. Navy in 1964-66. His principal assignment was Senior Medical Officer at the U.S. Naval Station in Key West.

Dr. Deal is a member of the Alachua County Medical Society, the Florida Medical Association, and the American Medical Association. In the FMA he serves as a member of the Committees on Medical Education and Continuing Medical Education. Other professional memberships include the Florida Heart Association, Florida Thoracic Society, Florida Public Health Association, and the American Society of Internal Medicine.

Dr. and Mrs. Deal, the former Elizabeth French Grayson, have two daughters, Kimberly Cawthorne and Kathleen Louise.

FMA Awaits Federal Court Decision On Disclosure Injunction

As this issue of *The Journal* went to press, the Florida Medical Association was awaiting a court decision on its suit to prohibit the government from disclosing Medicare payment information.

Sitting in Ocala, U.S. District Judge Charles R. Scott conducted a hearing on May 16 as a prelude to ruling on a preliminary injunction against the U.S. Department of Health, Education and Welfare.

HEW had planned to make public on or about April 30 fees paid to physicians for rendering services to Medicare patients. However, HEW's plans were set back when Judge Scott, acting in a suit filed by FMA, granted two successive 10-day restraining orders.

FMA contends HEW's disclosure plans have potential for many inaccuracies over which physicians would have no control; would violate physicians' rights under the Privacy Act; and would discourage physicians from treating Medicare patients.

U.S. Magistrate Harvey E. Schlesinger conducted an evidentiary hearing on the FMA complaint in Jacksonville in April. In a report to Judge Scott, Schlesinger held that HEW Secretary Joseph A. Califano, Jr., on the basis of current evidence, had abused his discretion in ordering disclosure. He recommended that the proposal to publicize fees be sent back to the Secretary for possible revision.

Schlesinger raised the question of whether the public's interest in total disclosure outweighs the privacy rights of physicians.

"The record is devoid of any evidence that the Secretary considered alternatives to full disclosure," the magistrate wrote.

FMA's suit also names as defendants Blue Shield of Florida and Group Health, Inc., of Miami, the Medicare fiscal intermediaries in Florida.

The President of the United States of America
The White House
Washington, D.C.

Dear Mr. President:

The House of Delegates of the Florida Medical Association which represents 12,000 Florida physicians at its annual meeting in Hollywood, Florida, on May 7, overwhelmingly adopted the following resolution:

Whereas, The President of the United States has recently stated that organized medicine is more interested in the financial protection of its members rather than the advancement of medical science and patient care; and

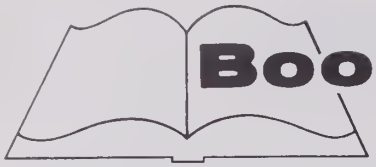
Whereas, Medical physicians are profoundly hurt and discomforted by this attack on them and their patients' confidence; and

Whereas, The history of American medicine indicates that it is the most advanced and progressive in the world and has consistently over the years demonstrated by its actions concern for the patient rather than itself, therefore be it

RESOLVED, That the House of Delegates of the Florida Medical Association go on record as respectfully repudiating the unjustified attack by the President of the United States on the American Medical Association and the physicians, patient care and advancement of medical science which it represents.

O. William Davenport, M.D.
President
Florida Medical Association, Inc.

cc: Florida Congressional Delegation



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

AMA Drug Evaluation, 3rd Edition. Price $29.50. 1,325 Pages. Publishing Sciences Group, Inc., Littleton, Massachusetts, 1977.

This edition of a valuable reference guide includes some 60 new drugs marketed since the previous issue, and is almost 300 pages longer. Prepared by the AMA Department of Drugs in cooperation with the American Society for Clinical Pharmacology and Therapeutics, it marks the initiation of a joint cooperative effort. Written by the AMA Department of Drugs professional staff, reviewed by several hundred distinguished consultants and then subjected to final review by experts appointed by the American Society for Clinical Pharmacology and Therapeutics, it represents a distillation of the current scientific literature plus the combined wisdom of many experienced clinicians. As with earlier editions, this issue has been organized into chapters and sections that are based on therapeutic classifications. A long introduction entitled "General Information" gives instructions in prescription writing, includes advice on monitoring adverse reactions and discusses drug interactions beginning with the well known synergistic effect of alcohol and barbiturates. Included are tables compiling the mechanisms of some interactions of clinical importance.

In the chapter entitled "Antianxiety Agents," the effects of barbiturates are compared to Meprobamate (Miltown) and Diazepam (Valium), the latter, having a long half life of over three days, may be given once daily after the first week to prevent some of the drowsiness associated with daily ingestion.

In a section of the book entitled "Drugs Used for the Relief of Pain," there is a chapter on "Strong Analgesics" which includes pentazocine (Talwin) and oxycodone (in Percodan) while "Mild Analgesics" contain propoxyphene (Darvon, Dolone, SK65) plus codeine and aspirin. Elsewhere in this section is a chapter entitled "Agents to Treat Migraine." There is a separate chapter on Penicillins, another on Antileprosy Agents and one on Antifungal Agents.

The prescriber is cautioned that all minerals are toxic at high levels in a chapter on "Vitamins and Minerals" and further advice is given that the most desirable source of vitamins is food so there are few valid indications for prescribing vitamins in this country other than correcting a deficiency.

To make the book more valuable, drug uses, routes of administration and dosages are described that may or may not be found in the "Package Inserts." While such FDA-approved labeling limits the marketing and advertising of drugs, it does not constrain the physicians' use of a drug for an individual patient, so that "Drug Evaluations," in providing all scientific and recognized uses of drugs, gives the physician an option not found in other references.

This book, priced at the cost of a shirt and tie, is a worthwhile addition to every practitioner's library and would be of extreme value to the medical student in his clinical years.

C.M.C.

Lifelines by Lynn Caine. 240 Pages. Price $8.50. Doubleday & Company, Inc., Garden City, New York, 1978.

In this book the author addresses the woman—alone or married — who feels lonely and isolated, sharing her own experiences with death and grief. She describes her search for fulfillment as a single woman, her struggles as a single parent and the devastating effect which the success of her first book had on her life. She discusses the particular problems women have in dealing with loneliness such as loss of self worth, depression, self-pity, and that "trapped feeling."

This book is a blend of personal testimony, philosophy and practical advice by a woman who lived through these problems and slowly and painfully learned to overcome them and find peace within herself.

L.R.

Plagues and People by William H. McNeill. 340 Pages. Price $3.50 (paperback). Anchor Press/Doubleday, Garden City, New York, 1977.

Dr. McNeill, Professor of history at the University of Chicago, has achieved quite a remarkable volume in **Plagues and People**. Part fact and part hypothesis, the whole is an intriguing and provocative view of world history. Dr. McNeill sees mankind in a precarious equilibrium between the microparasitism of disease organisms and the macroparasitism of large-bodied predators, chief among which have been other humans. Most historians have concentrated on the macroparasitism of mankind while Dr. McNeill, in this volume, concentrates upon the effects of microparasitism on mankind's evolution. The author quite skillfully sets the social, political and immunologic stage for many of mankind's most devastating epidemics and, in so doing, describes how many of these epidemics have quite strikingly altered the course of human history. A striking example of such an effect is the complete decay of the Central American Indian population in the face of Cortez' armies, bringing smallpox from Europe to the unimmune Indian people. The book is well documented in an extensive section of notes. Overall, this book provides a fascinating and refreshing view of world history which should be of extraordinary interest to the medical practitioner. It is highly recommended for leisure reading.

Bradley M. Rodgers, M.D.
Gainesville

Dr. Rodgers is Associate Professor of Surgery and Pediatrics, Department of Pediatrics, University of Florida College of Medicine, Gainesville.

Fear less, hope more;
Eat less, chew more;
Whine less, breathe more;
Talk less, say more;
Hate less, love more;
And all good things are yours.

Swedish proverb

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Labor & Delivery, An Observer's Diary by Constance A. Bean with an introduction by Gerald Cohen, M.D. 203 Pages. Price $7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Clinical Cardiology by Maurice Sokolow, M.D. and Malcolm B. McIlroy, M.D. 659 Pages. Illustrated. Price $16.00. Lange Medical Publications, Los Altos, California, 1977.

Occupational Diseases: A Syllabus of Signs and Symptoms by E. R. Plunkett, M.D. 352 Pages. Price $22.50. The Barrett Book Company, Stamford, Connecticut, 1977.

Current Medical Diagnosis & Treatment by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1098 Pages. Price $17.00. Lange Medical Publications, Los Altos, California, 1978.

The Compulsive Overeater, Seven Steps To Thin Sanity by George F. Christians. 100 Pages. Price $5.95. Doubleday & Company, Inc., Garden City, New York, 1978.

DNA Repair Processes, Edited by Warren W. Nichols, M.D. and Donald Murphy, Ph.D. 286 Pages. Illustrated. Price $29.95. Stratton Intercontinental Medical Book Corporation, New York, 1977.

Current Pediatric Diagnosis & Treatment, 5th Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1102 Pages. Illustrated. Price $17.00. Lange Medical Publications, Los Altos, California, 1978.

Chelation Therapy in Chronic Iron Overload, Edited by Edward C. Zaino, M.D. and Richard H. Roberts, M.D. 140 Pages. Illustrated. Price $17.95. Stratton Intercontinental Medical Book Corporation, New York, 1977.

The Health of the People. 140 Pages. Illustrated. Chris van Rensburg Publications (Pty) Ltd., P.O. Box 25272, Ferreirasdorp, 2048, Johannesburg, Republic of South Africa, 1977.

Annual Review of Neuroscience with 28 contributing authors. 506 Pages. Illustrated. Price $17.00. Annual Reviews, Inc., Palo Alto, California, 1978.

Que Paso? An English Spanish Guide for Medical Personnel, Third Edition revised and expanded by Martin P. Kantrowitz, M.D., Antonio Mondragon and William Lord Coleman. 69 Pages. Illustrated. Price $2.95. The University of New Mexico Press, Albuquerque, 1978.



Others Are Saying

The "Medicaid Mess"

"The Medicaid Mess" is the journalistic expression generally used to describe the present state of the Medicaid program. This program was originally designed to provide adequate, satisfactory, and necessary medical care to the indigent and needy utilizing a combination of State and Federal funds for its costs. All patients would ideally have become "private" patients and the old concept of the "clinic patient," usually a **number** in a crowded waiting room, would have been dispensed with. Regretfully, this ideal has not been reached in most states and especially this is true in our fair state of Florida.

The reasons for the abysmal failure of Medicaid to attain its lofty goals are manifold. Regrettably, most of the public criticism has been leveled at organized medicine and physicians, specifically. We have been variously described in the press as "money-grabbing" charlatans who have willfully abused the Medicaid principle. Under the microscope it has been found that most of the abusers are outside of organized medicine and the few within organized medicine constitute a small percentage of physicians who accept Medicaid patients. Very little press attention is focused upon hospitals, nursing homes, pharmacies, home health agencies, laboratories, and other paramedical professions who utilize the bulk of the Medicaid funds. Again, almost nothing is said about the millions of patients who abuse the Medicaid system — the consumer abuser.

The argument here is that the principle of a Medicaid system is a good one that can be made to function properly. It is apparent now that the original program was established hastily with majority input from the bureaucrats and only a modicum from the medical profession. The contribution from the medical profession in structuring the program must have been very slight or medical input was provided by medical professionals who have little direct contact with medical type patients.

The present structure of the Medicaid program consists of the consumer (patient), the provider (physician, hospital, nursing home, pharmacy, etc.), and the Administrator, (HEW and State of Florida). Most of the public blame for the malfunctioning of the Medicaid program is directed at the **provider**, a small part of the failure is attributed to the administration, but almost no charges of abuse nor overutilization are leveled at the consumer.

Any physician who sees Medicaid patients regularly can testify as to the number of patients who seek medical attention simply because they received a new card in the mail, or those with minor complaints for which they would ordinarily forego a visit to a physician if they had to pay for it. Pharmacists can detail the number of "shoppers" who visit several physicians and sometimes duplicate the same prescription. They can also describe those persons who are determined to obtain twenty dollars ($20.00) limit of drugs for each month whether they are needed or not. There are also the Medicaid consumer abusers who under closer scrutiny would probably not qualify for the program. Many of these persons are gainfully employed but are able to hang on to their cards by deception or falsification.

Is there a solution to the "Medicaid Mess"? In a nation with a gross national product counted in the trillions of dollars why should a health care program costing a few billions of dollars not succeed? A nation that could afford to expend billions of dollars in the Korean War and Vietnam debacles; that can spend billions of dollars to explore space; a nation whose commitments to defense and foreign aid programs measures in multi-billions, could easily support a well organized program for health care to the indigent and near indigent.

The Medicaid program is a worthy effort and only requires some revamping to make it functional. The benefits that could derive from preventive medicine alone could recoup its costs over the long run. In Florida, for the past year, the administration has decreed that no surgery can be done under the auspices of the program that can be safely postponed for six months. In theory this means that a hernia has to incarcerate or a gallbladder with stones has to become acutely inflamed before a patient can be admitted for needed surgery. The possibility of complications in both these instances could well double or triple the costs to Medicaid for hospitalization.

The mechanics of the Medicaid effort should be programmed by providers, especially physicians and others with experience in treating indigent patients and are cognizant of their peculiar problems. The mechanism should also include consumers who will benefit directly from the program as well as the bureaucrats and professional groups who ordinarily formulate policy. Changes should include:

- A deductible payment by the consumer to the extent of his ability to pay. This could be determined by careful, close screening of the applicant's financial status and indebtedness. The only persons that might be excluded from paying a portion of their medical bill would be those on the Medicaid-65 program or those who are total wards of the state.
- Providers should be paid UCR (usual, customary, and reasonable) fees. This would result in almost unanimous participation by the medical profession. A portion of this fee would be paid by the consumer as indicated previously. Provider abusers would be monitored and eliminated from the program by a properly functioning PSRO.
- A closer scrutiny of consumers. Determination of eligibility should be made on the basis of actual need rather than upon assumed need. Higher income does not always presume lack of need nor does lower income always presume a real medical need.
- A practical evaluation of the so-called "health industry," meaning the newer groups and agencies organized specifically to avail themselves of Medicaid and Medicare money by offering exotic and questionable services beyond actual need.
- Encourage the formation and function of PSRO's to monitor services provided.
- Improve payment and billing procedures.

Medicaid can work. Medicaid should be made to work. A properly designed and functioning Medicaid program can provide the framework for national health insurance which this country will eventually have. Organized medicine can and should help make it work. Let us hope that the new administration in Washington will, among other things, concentrate upon cleaning up the "Medicaid Mess."

F. A. Smith, M.D.
Tampa

Reprinted from the Editors' Column in The Bulletin of the Hillsborough County Medical Association, January 1977.

Office Hours

This letter should be of interest to our members. It addresses an increasing problem in our county.

Dear Dr. Stambaugh:

This is in response to your letter of September 16, 1977 concerning certain physicians who maintain an office practice from 9:00 A.M. to 5:00 P.M. and advise patients that they are not available before or after these hours.

This was presented to our Board and discussed. There are no statutory requirements that would require a physician to provide medical services to their patients for twenty-four hours a day, nor does our Board have any guidelines or rules regarding this. The Board Members were unanimous in their opinion that such a medical practice limited to these hours is entirely contrary to established ethical and moral principles in the practice of medicine and is an abrogation of responsibility on the part of the physician and, of course, would leave the physician liable to the charge of abandonment or enhance his chances of malpractice action should he not be properly available.

These physicians should be advised that if they are going to practice medicine, then they should practice it and assume the responsibility of twenty-four hour coverage, either by themselves or someone else. If they are not going to do this, then they should go into some business which allows 9 to 5 hours.

I am personally shocked at such an arrangement and I feel that such physicians can only bring discredit upon our profession and if allowed to continue, they would bring well deserved criticism upon themselves and upon all others in the community.

I would urge that local physicians express their strong feelings to these physicians concerning this.

Sincerely yours,
George S. Palmer, M.D., Executive Director
Florida State Board of Medical Examiners
Tallahassee

Reprinted from The Bulletin of the Palm Beach County Medical Society, November 1977.

Approaching High Noon

There is justifiable uneasiness and tension in our medical community these past few years. A confrontation is steadily brewing with preliminary skirmishes. We are now being attacked again by still another branch of the government called the Federal Trade Commission.

In December, the FTC, through the courts, issued a complaint against the AMA for illegally restraining competition by following our own ethics pertaining to advertising. We lost, but it is currently being appealed.

In February, 1976, the FTC probed Blue Shield for price fixing. Also in February, 1976, the FTC announced another probe of the AMA for illegally restraining the supply of physicians and services. In August, the FTC and the state slid the disastrous substitution law which, in effect, gives the pharmacist the right to practice medicine by legalizing him to change prescriptions — whether or not they were bioequivalent. The FTC, incidentally, was originally conceived by the Constitution to regulate commerce with foreign nations, the several states, and the Indian tribes.

Are we any of these?

Because of these repeated invasions of the private sector of medicine, many are questioning and writing about the constitutionality of these repeated and devious assaults. There is no power granted for the government to act in any way upon the practice of medicine.

We have seen the horrible mess and extremes of the Medicaid programs. On the one hand there is no control — and on the other, the faulty subsidizing and limitations only guarantee that the Medicaid patient receives inferior care. Coming with the new regulations will be the number of times we may see a patient; the number of tests we can do in what kind of setting; and the absolute number of days allowed for treatment. With this basis for guidance we will then have the same procedure regulated for Medicare, and probably for other medical programs as well.

In providing for the general welfare the Constitution *restricts,* rather than *grants,* taxation power. There really is no authorization for a class legislation such as Medicaid since the Constitution prohibits taxes to support it!

Next to come will probably be the fixed fee assignment by the government for treating diseases and patients. By this time it will be righteous to do the same thing that we have been unjustly accused of now, namely, price fixing. Before this happens we can expect some delay because of greater priorities of the present administration. Inflation, Ecology, and Defense should rightly be on top. Health Care is number eight or nine on the "urgency list." But it will come.

No one knows whether National Health Insurance will be the AMA plan, the Health Insurance Plan, the American Hospital Association Plan, the Kennedy-Corman Plan, a combination of the above, or a newly devised plan.

The Kennedy Bill is a real ringer!! It will eventually cost the government $130 billion more than the present government and all the private sources now spend together. The "Ringer" part is that the government will borrow more money and raise taxes. Here comes the violation of the Constitution again mentioned above.

To help absorb these costs, the physician will be forced to see sixty percent more patients. Yet our income, by decree, will be cut twenty percent off our net income at the same time our overhead increases ten percent because of the increased volume. This will come about by the now honorable price fixing by the government. The Trapnell Study (Jan., 1977 — Private Practice) indicates there will be trouble for physicians beyond anything discussed or acknowledged in Washington. These Washingtonian decisions, moreover, will be made by people openly hostile to the medical profession. The issue and principles involved won't settle themselves because the issues and principles involved are not identical. Thus, the confrontation.

Time, at this point, is in our favor as the public becomes more knowledgeable about the costs versus the questionable benefits of a popular but foolhardy plan. This is a plan that proves how wealthy the country is while it is going broke. The concerned physician fears.

The most drastic and usually the most effective remedy for fear is direct action. We know this. Yet our members are reluctant to even vote, let alone act in a united manner. If our membership will not show more attentive and constructive direction to our leaders and the countdown to socialism or unionism continues, we will certainly have no other choice except one or the other. One is inaction on our part and the other is direct action. Direct action is like a gun which may be loaded and therefore potentially dangerous.

To get out of this difficulty we will have to go through it together. We cannot go around it.

It's near High Noon. Decide!!

Edward W. St. Mary, M.D.
Miami

Reprinted from the "Editorial Page" of Miami Medicine, March 1977.

We Need To Look After Our Own

During the course of one's medical practice it is always disheartening to learn of the loss by death of a local medical friend and colleague. By the same token it is equally sad to hear that a fellow physician has been incapacitated and unable to work because of severe illness or injury. Unfortunately, whenever such ill fate occurs members of the stricken medical family may well suffer considerable emotional and financial hardship often with little or no support from the active medical community.

At present there is no permanent organization of local physicians either within or outside the realm of the Duval County Medical Society which is concerned with the welfare of wives and children of deceased or disabled doctors. Thus far, the only definitive activity in this regard has come from physicians who in the past have volunteered both time and money for specific cases. Although this type endeavor is indeed worthwhile and commendable, it falls short of providing a solution to the overall problem.

For those who accept the conviction that the local medical community should look after its own, it is important that we begin with a practical program which fully takes into account our resources at hand. With this in mind, I wish to propose that the county medical society and auxiliary establish a joint standing committee to consider and deal with problems of needy medical families. It seems reasonable to assume that the members of such a committee could render valuable assistance by visiting families to ascertain particular needs, render moral support, arrange for voluntary help when feasible, and provide information about rehabilitative services including financial aid available through the Florida Medical Foundation (a non-profit corporation supported in part by contributions from the medical auxiliary of the FMA). As an additional approach to this matter, I wish to suggest the possible formation of a local *"Medical Widows and Orphans Society."* Most societies of this type are comprised of volunteer members of the medical profession who are required to pay dues which in turn are used to provide financial assistance to deprived medical wives and children. Obviously, there is no way to completely fulfill the total needs of every deserving family; however, I would submit that a little help, even if it be moral support alone, is better than no help at all.

Daniel B. Nunn, M.D.
Jacksonville

Reprinted from the Editorials-Letters-Viewpoints page of the Jacksonville Medicine, August 1977.

Medical Mediation Panel System

If someone is injured by the carelessness of another, he is entitled to collect damages. This includes patients injured by the failure of a doctor or hospital to use the care which should be required of them. It is the job of the Court system to determine if the doctor or hospital was negligent and, if so, what damages should be paid.

Unfortunately, when medical treatment is not successful, the resulting damages are very high. The enormity of the damages encourages both injured patients and their lawyers to press claims based upon alleged medical negligence that is sometimes considerably less than obvious. The medical malpractice insurance carriers, to avoid the risk of a bad verdict and the expense of the lawsuit, make settlements. This in turn encourages more claims filed with only slight basis or at least without sufficient investigation.

The filing of suits against doctors and hospitals could, and in some areas did, reach the point that many doctors felt forced to practice "defensive" medicine. Their medical judgments had to be affected, not only by the patients' welfare but by possible personal liability. In the pool hall parlance of my youth, doctors had to "shoot a scared stick."

This was no way to practice medicine and it certainly is no way to run a Court. The Court system is intended to protect people and encourage people to do right. Its use, or threat of use, to defeat justice, or for harrassment, angers our judges probably more than any single item.

To help weed out the spurious claims while recognizing and encouraging settlement of legitimate malpractice claims, our Legislature established the Medical Mediation Panel System.

In some areas of the State either the judges, the lawyers, or the doctors, or all of them, have hampered or defeated the system as a waste of time and just another piece of foolishness passed in Tallahassee.

I am pleased to say that in Polk County we have

attempted to make the system work — and with considerable success.

The key to its success or failure is the caliber of the panels. If we do not continue to have our experienced lawyers and doctors with sound judgment on the panels, it will become a waste of time.

I am embarrassed to confess that the Courts in Polk County have sometimes done a very poor job of coordinating and informing the panel members. We presently have a joint medical-legal committee now completing recommendations on means of improving the local administration of the system.

Past mistakes, which I am determined to see corrected, include failure to give panel members adequate notice of the hearing date, failure to expedite proceedings at the hearing, failure to promptly (if at all) notify the panel members of postponement or cancellation of hearings, and failure to let the panel know in advance what the claim is all about.

I urge both the legal and medical professions here to continue to cooperate in the Medical Mediation Program. I am convinced that it is improving the administration of justice and can improve medical care by assuring both doctors and patients of a fair shake.

Sincerely,
John H. Dewell, Chief Judge
Tenth Judicial Court

Reprinted from The Imperial Polk County Medical Association Bulletin, December 1977.

Why Are Hospital Costs So High?

Hon. William F. Walsh in the House of Representatives, Tuesday, March 1, 1977.

Mr. Walsh: Mr. Speaker, few of us can afford, literally, to be ill these days, especially when it involves a stay in a health care institution. Rising hospital costs constitute an increasingly alarming problem, yet many of us do not know its cause. Mr. William J. Watt, assistant administrator-comptroller of St. Joseph's Hospital Health Center, located in Syracuse, N.Y., has put together what I consider an excellent analysis of the problem. Mr. Watt's familiarity with hospital costs began in 1967 when he assumed the position of comptroller of the University Hospital, Upstate Medical Center in Syracuse, and he has been in this business ever since. I am confident all of us will find this gentleman's comments to be both informative and helpful, and I am pleased to insert it in the *Record*:

Why are hospital costs so high? In plain layman's language, why are costs so high? You, the public, ask that question every day. Let me try to answer. You probably have a favorite grocery store at which you do your weekly shopping. Let us impose some changes in the way that store operates.

1. The store must record and report each year the number of cans of peas sold by brand, by customer age and by employer of the customer. For example: report sales of "Green Giant" peas to General Electric employed customers by age groups 1 to 5, 6 to 16, 17 to 21, etc. The same for "Green Giant" pea sales to customers employed by Chrystler Motors and so on. Next, store will report on "Libby" peas. We will require this report on not only peas, but for each and every product sold.

2. The store must certify in writing that each customer "needs" groceries before permitting him/her to enter the store.

3. The store must have a "committee" to establish a shopping "time limit" for each customer as he/she walks in the door. Any customer permitted to shop longer than the pre-established time limit may not be required to pay for groceries. The store must keep records of this by customer.

4. The store must keep a record by name of time customer entered store, items purchased, amount paid by item, name of stock boy who placed each item on the shelf, time of customer departure from store and name of store employee who carried the groceries out.

5. The store must obtain approval of the "authorities" before adding or deleting any product or specific brand of product.

6. The store manager must have a Masters Degree in Marketing.

7. Periodically, the store will be required to determine and report "race" of each customer in store during a particular day.

8. The store must keep records and report the following to our authorities:

a. Total number of customers served, broken down by employer.

b. Total minutes of customer shopping.

c. Number of customers who used shopping carts.
d. Number of customers who did not.
e. Number of customers who bought meat and nothing else.
f. Number of customers who bought bread and nothing else.
g. Number of customers who bought milk and nothing else.
h. Number of customers who bought bread and milk.
i. Number of customers who bought bread and meat.
j. Number who bought meat and milk.
k. Number of customers who came in for one item only but bought two or more.
l. Number of customers who went directly to the left side of the store upon entering.
m. Number who went directly to right side of store.
n. Number who sauntered down in the middle aisle.

9. Let us now mandate that the store "give away" five thousand dollars worth of groceries each year. In fact, let us force the Store Manager to post signs in three languages telling customers that he is required to do this; and again, records must be maintained by customer on free groceries given away under this plan, as well as records on those denied.

10. Next, let's require that for one half of its customers, the store cannot set prices. Instead, our authority will determine how much the customer may be charged. Better yet, we will tell the manager that these customers may be charged no more this year than last year prices — regardless of how much more the store must pay for the items and regardless of how much our new regulations have added to operating costs. After all, the store can double its price increases to the other half to make up any loss.

11. For that half of the customers, let us also require that the store cannot collect from the customers for groceries sold. Rather, the store must bill the customer's employer. Better yet, we will mandate that the store must first write to the employer for "permission" to bill, then it may bill upon receipt of permission. In the meantime, the store may not attempt to collect from the customer for groceries received.

12. Naturally, we will establish that the store is to be "fined" if it refuses to report the data we have outlined or if its records are not totally accurate.

13. For topping, the store must hire an independent accountant to certify the accuracy of data reported under our regulations.

14. To wrap things up, let's make the store manager responsible for planning each customer's meals. If he errs in judging what is best for a family — sue, sue, sue.

15. Let's not stop here just because you and I have exhausted our ideas. Why not add more people to each of the authorities? They will probably invent new controls and regulations to show they are earning their pay.

16. Finally, why are grocery costs so high now? In plain laymen's language, why are they so high?

It sounds ridiculous to apply such criteria to a grocery store, doesn't it? But believe it or not, hospitals are mandated by several "authorities" to report countless statistical data and are bound to many, many rules — not unlike those we have dreamed up for our grocery store. Some examples of these are:

1. Report monthly and annual days of inpatient care, by age group, by services (medical, surgical, etc.), by type of financial coverage.
2. Report outpatient visits in a similar fashion.
3. Likewise for Emergency Room visits.
4. Report total annual minutes of anesthesia time administered.
5. Count and report number of x-ray examinations.
6. Count and report number of films used in these x-ray examinations.
7. Report number of births each year.
8. Report number of children served.
9. Report number of physical therapy treatments.
10. Report number of blood transfusions.
11. Number of patients admitted as inpatients.
12. We must give a certain amount of "charity care" each year and have multilingual signs posted telling our patients this charity is available.
13. Report operations by number and type of operation.
14. Reimbursement rates are established by outside "authorities" for more than half of total patients. Such rates are usually less than the cost of care, so we charge higher fees to the remaining half to make up the deficit.
15. We must obtain a signed certificate as to need for hospitalization.
16. We must establish a "time limit" for hospital stay at time of hospitalization. An insurance clerk may declare an "overstay" and refuse to pay.
17. We must seek "permission" to bill an outside third party for more than half our patients.
18. We must maintain detailed records of services provided by date and by individual providing the service.
19. We must periodically determine and report the "race" of each patient treated during a given day.

(Editor's Note: This article is an exerpt from the *Congressional Record* of March 1, 1977.)

Reprinted from the Official Organ of the Florida Society for Respiratory Therapy, January 1978.

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Report of the President

Mrs. R. B. (Connie) Moore

Each year the Florida Medical Association Auxiliary President chooses a theme, which in her opinion, is most appropriate for the times. We all "dance to a different tune," so the theme is sometimes a reflection of the personality of the President, or a combination of that, plus the needs of the Auxiliary in keeping with our stated objectives, not the least of which is "to cultivate friendly relations and to promote mutual understanding among the families of medical doctors."

It is interesting to read the annual reports of the county Presidents and their reaction to "Reach Out . . . and Touch," the theme I chose after asking those attending the Leadership Conference in 1977 what they considered the greatest need of this organization. The Medical Auxiliary was founded over fifty years ago to meet a need which, when we review the history, is basically the same as at its inception. There are those, both physicians and spouses, who "see no need for an Auxiliary" and in some instances the physician forbids the spouse to join. A male physician in one county indicated to me that the lack of communication between the Medical Association and Auxiliary was because some men thought the "women were going to take over" . . . a statement I found both amusing and a bit sad. There are few who will read of the accomplishments of the Auxiliaries, local, state, national, and not be proud of the vision and dedication of those who have tried to carry out the wishes of the Medical Association, or if you will, the physician. I shall never forget how shocked I was when someone told me more than sixteen years ago, that "not all doctors' wives want to join." I had assumed they did; however, I have since learned the definition of "assume."

We learn a lot about people when we become "involved" in anything, from tennis, golf, and bridge to church and other community service. The Auxiliary is no exception. The doctors' wives and husbands that I have met through my activity in the Auxiliary have been concerned with the quality of medical care provided that community, and with the image of the physician and the physician's family. It is, of course, an individual decision to belong or not belong, and, thank God, we still have that choice. The public relations, if you will, that the medical auxiliary generates through the philanthropic and educational programs are hopefully enough to offset the image of those medical families who choose to do nothing but "take" from their community. Admittedly the doctor and his spouse can be a vital, concerned member of the community without being a member of the association, or its Auxiliary, and many are. I do, however, question the wisdom of statements made through ignorance of what the medical associations and their auxiliaries are trying to do.

A "more personal approach to meetings" was carried out by most of the counties this year. The new member coffees, interest groups, craft workshops, etc. as well as brunches, luncheons, and cocktail parties were held in the homes of members rather than a public building. Some counties tried the old "buddy" system, or the "big sister, little sister" approach and each member made herself responsible for a younger member (or new arrival) and picked her up for the get togethers. The membership chairman or the county president made a real effort to entertain new arrivals in town, and to sincerely get to know them and help them adjust to a new community, or in some cases, a new country.

In order to grow, an organization must be "alive and well" and have something to offer the membership. The FMA A has increased membership this year by 10%. There has been a tremendous effort of the FMA A Treasurer, First Vice President and Membership Chairman, and the county Treasurer and Membership Chairman to work closely together. This proved to be not only practical but profitable toward the growth; enlarging our membership is important insofar as educating members on what is available to them and what opportunity they have to serve the community through the Auxiliary.

Over $54,000 was raised for American Medical Association Education and Research (AMA ERF) through the Christmas or holiday Sharing Card, parties, boutiques, etc.; more than $8,000 was given to International Health through the Fall Conference Bazaar and county Bazaars — this money was divided between Medical Assistants Program (MAP), Scholarships for Kids of International Physicians (SKIP), and Interplast East, a program providing reconstructive surgery for patients who have to be brought to Florida because the hospitals are not equipped (in those countries) for

Mrs. Moore is Immediate Past President of the Florida Medical Association Auxiliary.

extensive surgery. One county alone raised over $12,000 in one evening to provide scholarships and to equip school clinics; thousands of dollars have been given to students going into medicine or a medically-related field.

While large sums of money have been raised for many different projects, the real emphasis should be placed on the good that money will do and the many ways a community will benefit from it. I would like to place emphasis on those volunteer hours spent in fund raising; on the volunteer hours spent in teaching over four hundred teens to be Good Emergency Mothers (GEMS); the thousands that have been taught Breast Self Examination (BSE) in their schools by wives of physicians, and in some cases, in cooperation with the Cancer Society; many auxiliary members have become certified in Cardiopulmonary Resuscitation (CPR) and in some counties they have taught public school teachers CPR. Not only have individual members "reached out" but the Auxiliary has made a great effort again to "reach out" to other organizations in the state, realizing that to be really effective we must all work together toward the goal foremost in our minds — better health care.

Cookbooks, cruises, seafood and citrus have been sold to benefit Florida Medical Foundation (FMF); "Worry Seminars" continue to be one of the most popular community services and they are filled with a waiting list in most instances. One county offers a "His and Her" Seminar with almost 50% participation from males. We have had requests from community leaders to offer this type program two and three times a year, rather than the usual one time.

It was unfortunate that the Florida Medical Museum, housed in the Old Spanish Hospital in historic St. Augustine, had to be closed. After investigating several places, the medical artifacts were moved to Tallahassee, our state capital, and given to the Museum of Florida History. When you are in Tallahassee, visit the new building near the new capitol. You will be proud to be a part of the history of this state.

The AMA Immunization program was implemented in some counties. The Hopscotch was painted on school lawns, museum floors, and the film showing the dreaded diseases is available on request from the state Auxiliary.

The Auxiliary is sponsoring an Organ Donor Bill which would provide a mini will on the back of every operators and chauffeurs license in the state. At the time you receive your Driver's License you could sign it and have it witnessed by any two people in the place where you get your license renewed. This would take the place of the optional donor card that was provided through legislation a few years ago.

One of the most popular programs this year, again because of the need to "reach out" was the International parties. We have so many physicians living in Florida from all over the world, it was the desire of many counties to provide some way to learn a little of their culture. This was done by pot luck dinners, with food prepared native to an individual member's country, to belly dancers with music of India provided by physicians from that county. A most enterprising Pediatrician in one county came dressed in jeans, etc. with a large bag of peanuts — he has a farm in Plains, Georgia!

I have tried, briefly, to mention a few of the things we do — I cannot possibly mention all of them.

As Auxiliary President, I have presided at all Executive Committee meetings, Board meetings, and the Annual Convention. The Executive Committee met following the annual meeting in 1977, before the fall conference in September, 1977; the winter meeting was held in February and again we met before the Board meeting in May. The Board of Directors have met in September and again in May. There have been numerous committee meetings. I have gone when asked to attend.

The FMA Board of Governors meeting in October was my first with that group. I was invited to the one in June, unfortunately they were meeting the day I was moving into our new home. I met with the FMA Executive Committee, the FMF, and reported to the Board of Governors. I was instructed to promote educational programs on FLAMPAC and Legislation and this has been done in every state meeting as well as the District Workshops.

It has been a privilege to attend the Auxiliary meetings in fifteen counties, two AMA Southern Regional meetings; 1977-78 AMA-A Conventions; AMPAC Seminar in Atlanta; all FLAMPAC workshops; Southern Medical in Dallas; Confluence in Chicago last October; Synergy in Leadership by the AMA in Chicago; a week in Tallahassee during the Legislative Session, in fact, when someone mentions the word "go," I snap to attention and ask "me?" — "Where to?"

Thank you for a wonderful year — packed with correspondence, seminars, meetings, luncheons, dinners, calories, and new friends from all over the state and nation, renewed friends from all over and hopefully I have kept all my old friends. I have loved it.

My year would not be complete without singing the praises of the FMA staff. Nowhere is there a nicer, more dedicated group than the FMA has in Jacksonville, Tallahassee, Tampa and Miami. Their total cooperation, help, and understanding have been constant.

"There cannot be a wholesome smile
Where bitter thoughts conspire —
Which only serve to disconnect
The heart pulse from the wire.
Our smiles are the sparks of love
Sent out when hearts are free —
Which generates a cheerfulness
For all the world to see."

MEETINGS

Approved by the FMA Committee on Continuing Medical Education

JULY

Examination of the Arterial System, July 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 522 West Highland Boulevard, Inverness 32650.

Clinical Family Planning for Physicians, July 17-18, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Laparoscopy Course, July 24-25, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Computerized Tomography and Patient Management, July 30 - August 2, Hyatt House, Orlando. For information: Lawrence R. Muroff, M.D., P.O. Box 17241, Tampa 33682.

AUGUST

Diagnostic Imaging of the Heart, Aug. 2-6, Hyatt House, Orlando. For information: Lawrence R. Muroff, M.D., P.O. Box 17241, Tampa 33682.

Clinical Electrocardiography and Arrythmia Management, Aug. 11-13, Hyatt House, Orlando. For information: William E. James, Ph.D., 64 Inverness Drive, Englewood, Colorado 80110.

Initial Management of the Pediatric Emergency, Aug. 23-27, Playboy Resort Hotel, Lake Geneva, Wisconsin. For information: Emergency Medical Services Symposia, Inc., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

Laparoscopy Course, Aug. 28-29, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

SEPTEMBER

Transient Ischemic Attacks: The Computerized EEG, September 11, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.

Fifth Annual Cardiovascular Symposium, Sept. 14-15, Hilton Inn, Gainesville. For information: Howard W. Ramsey, M.D., P. O. Box 13494, Gainesville 32604.

Anesthesiology Review and Update, Sept. 15-17, Sonesta Beach Hotel, Key Biscayne. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Sexual Medicine, Sept. 18, Sheraton Rivèrhouse Hotel, Miami. For information: Domeena C. Renshaw, M.D., 2160 South 1st Ave., Maywood, Illinois 60153.

Clinical Family Planning for Physicians, Sept. 18-19, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Laparoscopy Course, Sept. 25-26, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

OCTOBER

Current Concepts in Neurology, Oct. 12-14, Doral Country Club, Miami. For information: Allan Herskowitz, M.D., 155 Northwest 167th St., North Miami Beach 33169.

Laparoscopy Course, Oct. 25-26, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

NOVEMBER

Adolescent Medicine, Nov. 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Clinical Family Planning for Physicians, Nov. 13-14, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Laparoscopy Course, Nov. 13-14, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

DECEMBER

7th Annual Refresher Course for Nurse Anesthetists, Dec. 1-3, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Glaucoma Symposium, Dec. 7-9, University of South Florida Medical Center, Tampa. For information: W. E. Layden, M.D., P.O. Box 21, MDC, University of South Florida, Tampa 33612.

Cardiac Symptoms and Arrhythmias — Their Diagnosis and Treatment, Dec. 8-10, Americana of Bal Harbour, Miami. For information: IMEC, 64 Inverness Drive East, Englewood Colorado 80110.

Coronary Disease, Exercise Testing, and Cardiac Rehabilitation, Dec. 8-10, Konover Hotel, Miami. For information: IMEC, 64 Inverness Drive East, Englewood, Colorado 80110.

Laparoscopy Course, Dec. 11-12, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

1979

FEBRUARY

Second Symposium on Neurological Surgery of the Ear, Feb. 3-8, Sarasota. For information: Ms. Susan G. Brown, 1845 Hillview Street, Sarasota 33579.

***For information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONERS

FAMILY PRACTICE — Excellent opportunity for physician to perform general practice in expanding North Florida community. Attractive 128-bed new hospital that provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

GENERAL PRACTITIONER: For well equipped medical clinic immediately adjacent to 120 bed skilled nursing facility; would also act as medical director for nursing home. Salary 100% of intake. Contact: Administrator, Wakulla Manor Nursing Home, P.O. Box 508, Crawfordville, Florida 32327. Phone: (904) 926-7181.

FAMILY PRACTITIONER OR INTERNIST WANTED to share facilities with four practitioners in solo practice. Major equipment provided. Rent $250 per month. Competent laboratory and x-ray with income based on use. Bookkeeping system and receptionist shared. Financial assistance available to right party. Contact: T. C. Kenaston Jr., M.D., Box 550, Cocoa, Florida 32922.

FAMILY PRACTITIONER/INTERNIST, board eligible or certified with some subspecialties. Excellent opportunity for private practice in West Broward, fastest growth area. Modern JCAH accredited 301-bed hospital. Office space available. Financial security. Hollywood/Ft. Lauderdale. Pembroke Pines General Hospital, 2301 University Drive, Pembroke Pines, Florida. Rubin Piha, Administrator. Phone: (305) 962-9650.

GENERAL PRACTITIONER OR INTERNIST: Excellent opportunity, assume long established practice with a multispecialty group. Present associate leaving the area. Florida license required. Please submit Curriculum Vitae to John F. Kerwick, Hollywood Clinics, P.A., Box 2308, Hollywood, Florida 33022. Phone: (305) 923-4646.

FAMILY PRACTICE — Two man family practice looking for third man. Location South Florida, Pompano Beach area. Contact: P.O. Box 757, Pompano Beach, Florida 33060.

SPECIALISTS

CARDIOLOGIST, FAMILY PRACTITIONER. Immediate openings. Private solo practices, except FP could be partnership. Financial assistance including first year rent free in professional building adjacent to hospital. Contact Claude Weeks, Executive Director, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

PEDIATRICIAN. Immediate opening. Most attractive opportunity to assume well-established private, solo practice. Financial assistance including first year free rent in professional building immediately adjacent to hospital. Casual Florida living at its best. Contact Claude Weeks, Executive Director, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

DERMATOLOGIST, FAMILY PRACTITIONER. Immediate openings. First year free rent and equipment loan. Private, solo practices in professional buildings immediately adjacent to hospital. Contact: Claude Weeks, Executive Director, Flagler Hospital, P. O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

ORTHOPEDIST: CASUAL FLORIDA LIVING AT ITS BEST. Immediate opening for solo, private practice. Free rent first year. Contact Claude Weeks, Executive Director, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

TWO BOARD CERTIFIED INTERNISTS actively seeking third associate in busy clinical practice. Internal medicine with or without subspecialty training — Southeast Florida Coast. Contact: Yale Citrin, M.D. or Peter S. Irving, M.D., 3435 Johnson St., Hollywood, Florida 33021.

IMMEDIATE OPENING for general internist Miami. 40-60 years preferred. Salary plus override, malpractice and major medical. Reply to: C-871, P.O. Box 2411, Jacksonville, Florida 32203.

CARDIOLOGIST — Immediate opening for Cardiologist or Internist with special interest in cardiology in a semi-rural central Florida community. 135-bed community hospital building new 12-bed CCU. Four family practice physicians practicing quality medicine will provide modern office and guarantee starting salary. Liberal fringe benefits including profit sharing, professional liability insurance, etc. Please reply to: C-877, P.O. Box 2411, Jacksonville, Florida 32203.

TWO YOUNG FLORIDA ORTHOPEDIC SURGEONS SEEKING THIRD ASSOCIATE in Gulf Coast practice, rapidly growing waterfront community of 50,000. Board certified/eligible, interest in hand/scoliosis desirable. Corporate benefits very substantial. Write C-878, P.O. Box 2411, Jacksonville, Florida 32203.

MISCELLANEOUS

LAMINAR FLOW OPERATING ROOMS tested for conformation to Federal Standard 209-B, also yearly recertification test performed. Contact Jake Truslow Company, P.O. Box 1359, Melbourne, Florida 32901. Phone: (305) 723-3382.

ASPEN MUSHROOM CONFERENCE. Identifincation of edible, poisonous, and hallucinogenic mushrooms. Treatment of mushroom poisoning. Microscopy. Novice and advanced courses. AMA category I, August 13-18, 1978. Wildwood Inn, Snowmass-at-Aspen, Colorado. Contact Beth Israel Hospital, 1601 Lowell Blvd., Denver, Colorado 80204. Phone: (303) 825-2190 Ext. 359.

SPARKLING CLEARWATER AND CLEARWATER BEACH. BE THE ONLY PHYSICIAN on an exclusive island residential community of 4,500 between Clearwater and Clearwater Beach. 1,324 sq. ft. office in a new Mediterranean-styled neighborhood shopping center. Five minutes to Morton Plant Hospital, pharmacy in shopping center. Call 1-(800)-432-2199.

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FACULTY POSITION: Department of Community Health and Family Medicine, College of Medicine, University of Florida. Board eligible or certified family physician to assume leadership of a well-established rural clinic near Gainesville. Applicants must be interested in living in small community but with active involvement in medical school based program. Supervision and teaching of medical students, residents, physician's assistants plus direct patient care. Opportunities for primary care research. Contact: W.J. Coggins, M.D., Chief, Division of Rural Health, College of Medicine, University of Florida, Gainesville, Florida 32610.

Situations Wanted

GENERAL AND VASCULAR SURGEON, 35, university trained, board certified, Florida licensed. Seeks practice opportunity, solo, partnership or group. Available 3 months notice. Write C-837, P.O. Box 2411, Jacksonville, Florida 32203.

POSITION WANTED: 35 years old, board certified general surgeon, wishes to relocate in Florida. Group, hospital based or partnership. Contact: Jorge A. Melandez, M.D., F.A.C.S., One Hillside Drive, Batavia, N.Y. 14020. Phone: (716) 343-5563.

CARDIOLOGIST, board certified, 35, skilled invasive and noninvasive techniques, Florida licensed, desires relocation. Write C-861, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL SURGEON, FACS, 43, Endoscopy, wishes to relocate. West coast area preferred. Solo or partnership, will consider all offers. Write C-869, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN — Board certified, eight years experience, bilingual. Seeks position in suburb practice. Reply to: Olga Quintana Sheehy, M.D., 428 Henry St., Fairview, New Jersey 07022.

PATHOLOGIST-CERTIFIED CP/AP, Florida licensed, native U.S., excellent C.V. and experience as director. Current postgraduate training and certification through 1980. Write: P.O. Box 11185, U.S. Post Office, 227 E. Ontario St., Chicago, Illinois 60611.

UROLOGY RESIDENT, 33, married, American graduate, military completed, trained at large southeastern university, available October 1978, seeks opportunity in Florida. Write Robert Karp, M.D., 3021 Panaridge Circle, Birmingham, Alabama 35216 or call (205) 934-3411 #401.

PHYSICIAN'S ASSISTANT DESIRES EMPLOYMENT WITH PEDIATRIC emphasis. Other options welcome. Graduating from University of Florida/Santa Fe Program on July 22. Currently a Registered Medical Technologist. Write: Jerry Janiec, B.S., 4400 S.W. 20th Ave., Lot #219, Gainesville, Florida 32608.

CANADIAN GRADUATE, FLORIDA LICENSE seeking Family Practice association or O.R. assisting. Prefer West Palm area but other work or area considered. Contact: W. Markkanen, M.D., 3600 Ocean Drive, Riviera Beach, Florida 33404.

CARDIOLOGIST-INTERNIST, 34, FMG, fully USA trained. Board eligible. Expertise: Echo, Stress testing and all aspects of clinical cardiology. Available July 1978. Write: C-874, P.O. Box 2411, Jacksonville, Florida 32203.

CANADIAN ORTHOPEDIC SURGEON, age 45, FRCS(C), FLEX, seeks post in solo or group practice preferably along south Atlantic Coast or Sarasota area. Reply: C-875, P.O. Box 2411, Jacksonville, Florida 32203.

35 YEAR OLD MALE INTERNIST/NEPHROLOGIST. WIFE INTERNIST, would like to relocate in Florida. Would prefer solo or group practice. Please reply to: C-876, P.O. Box 2411, Jacksonville, Florida 32203.

Practices Available

GENERAL PRACTICE FOR SALE: Located in fast growing area in Tampa. Fully equipped. Will introduce. Reason for leaving: going into residency training. For further information write to: John A. Johnson, M.D., 13857 Oak Forest Blvd., North, Seminole, Florida 33542. Phone: (813) 393-9367 (nights).

FLORIDA INTERNAL MEDICINE PRACTICE WITH OFFICE BUILDING for sale for price of building and equipment alone. Practice, suitable for internist or G.P., is located in rapidly growing retirement community of 8,000 on Central Florida West Coast. Write or call: Kenneth C. Chessick, M.D., 2 West Lemon St., Beverly Hills, Florida 32661. Phone: (904) 726-9180.

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LARGE PRIVATE GYNECOLOGIC PRACTICE FOR SALE. Long-established and presently grossing at a large figure (given upon request). Multigeographic following. Group oriented with corporate-rent shares investment property. Date of sale and terms negotiable. Reply to: C-877, P.O. Box 2411, Jacksonville, Florida 32203.

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Equipment

NEW AUTOMOBILES. Save up to $1,000 on all U.S. makes. Statewide delivery with full warranty. For quote send itemized needs to Aristocrat Auto Brokers, 11125 S.W. 74th Ave., Miami 33156.

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LAKELAND, FLORIDA: FOR SALE 6% down. Air conditioned office for one to three physicians. Main Street, 168 x 140 ft.; double parking lots; extra cottage. Dr. L. Polskin, Box 15966, Honolulu, Hawaii 96815.

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WEST PALM BEACH. ONE STORY PURELY MEDICAL BUILDING. Beautiful central, easily accessible location on inland waterway (I-95 four minutes). Within geographic boundaries of all hospitals including Lake Worth. 1,100 sq. feet. Ready for occupancy. Reasonable. Phone: (305) 655-8620, evenings (305) 833-2952.

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FOR SALE — HIGHLANDS, NORTH CAROLINA. Completely furnished winterized three bedroom, two bath home — 1½ acres — trout pond — wood fireplace and deck. Spectacular view. Harry Long Realty, P. O. Box 156, Highlands, North Carolina 28741. Phone (704) 526-2453.

FLORIDA — SARASOTA. NEW MEDICAL ARTS BUILDING space for lease. Busy Bee Ridge - Beneva area. Will finish to your specifications. Completion March 1, 1978. Write for details. Allan M. Douglass, Heritage Company of Florida, 1859 Main St., Sarasota, Florida 33577.

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PHYSICIANS OFFICE SUITES, (900 and 1,200 square feet) in fast growing Ocala. Central location, unlimited parking, all utilities and janitor service furnished. Contact: E.E. Conrad, Owner, P.O. Box 216, Silver Springs, Florida 32688. Phone: (904) 236-2343 or (904) 236-2741.

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Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

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JULY 1978 • VOL 65 • NO 7

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PROCEEDINGS ISSUE

Florida Medical Association House of Delegates

May 3-7, 1978

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Anxiety...
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2.5 mg clidinium Br.
Antianxiety
Antisecretory
Antispasmodic
Librax is unique among G.I. medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.
*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on following page.
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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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JULY COVER — The photograph on the cover entitled "Bright Reflections" by Eric F. Geiger, M.D., of Pensacola, won the Editor's Award at the FMA Auxiliary's Twelfth Annual Benefit Art Show during the FMA Annual Meeting, May 3-7, 1978 in Hollywood.

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President's Page

National Health Insurance

If we can believe the newspapers and the political pundits, the big push for National Health Insurance is going to be this year, rather than two or three years hence. Indeed, for the past several months, there apparently has been a concerted effort (dare we say conspiracy) by various agencies in Washington which have released reports having a detrimental effect on the private practice of medicine. These reports frequently make the front pages, while refutations and reasonable responses are buried, if printed at all.

Assuming that the above is true, then the battle line will soon be drawn and in most cases will be clear cut.

*Who will be **against** us?*

First of all, the White House, which seems desperate in its efforts to appease certain special interest groups and to gain in the popularity polls.

The entrenched bureaucrats who, if not already, soon fall into a socialistic mold.

Labor bosses who have much to gain in retirement and pension funds.

Certain big business leaders who will benefit by eliminating health insurance from the bargaining table.

The news media which seems to delight in sensationalism concerning any field of medicine.

*Who will be **for** us?*

No clear cut group at the present time; therefore, we must begin to marshal our forces.

The small businessman could be a major ally since he is very familiar with the oppressiveness of big federal government. Therefore, our spokesmen could utilize the forum of service clubs and Chambers of Commerce to point out our positions.

Other professionals, such as dentists, veterinarians, nurses, technicians, school teachers and even lawyers, could possibly be enlightened as this menace most definitely poses a threat to them in the future.

The United States Congress is the most unpredictable body of people ever assembled. From all reports, most seem to feel that National Health Insurance is unaffordable at this time. But very few have the guts to denounce socialized medicine and acknowledge the serious danger to all of our freedoms that it poses. Nevertheless, this body may be our only salvation in the immediate future. We must intensify our communication with our Senators and Representatives in Congress.

Last, but not least, are our patients who cross all the lines of the aforementioned groups. Even though all the polls list physicians as the most respected profession, it seems difficult to broach the subject of politics to someone who is seeking help with a medical problem. Seminars by experts in the fields of salesmanship, public relations, etc., could be of help here.

Even though we are but one of 50 states, we are a very important "key" state in influence. We have provided national leadership in the past and will continue to do so. Our voices will be heard!

The time is near. We must develop a coordinated course of action soon. Please send me your thoughts.

O. Wm. Davenport M.D.

FLORIDA MEDICAL ASSOCIATION, INC.

Briefs

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No. 257
June 13, 1978

THE REGULAR SESSION OF THE 1978 LEGISLATURE ENDED JUNE 2. The FMA was successful in achieving its major legislative priorities including:

1. Provision for a constitutional separate Department of Health
2. Recovery of defense costs

The final document of the Constitutional Revision Commission contains a provision for a separate Department of Health. This major accomplishment, approved earlier this spring by the Commission by a vote of 29 to 8, is a major victory for the citizens of our state. The entire document will be placed before the Florida voters in November. A second major success was passage of House Bill 1062, Recovery of Defense Costs. The bill provides that a judge can award attorney fees "to the prevailing party in any civil action in which the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party.

The FMA successfully supported legislation for:

- Increased funding for the State Board of Medical Examiners
- Funding for Emergency Medical Services
- Continuing funding for the Comprehensive Health Education Plan.

The FMA was successful in its opposition to a rash of legislative proposals which would have an adverse effect on medicine:

- Legislation that would have eliminated Mediation Panels
- Certificate of Need for equipment in doctors' offices
- A proposal to create a commission to regulate hospital rate increases in Florida
- Legislation which would have expanded the authority of advanced nurse practitioners and would have eliminated the joint advisory board composed of members from the Board of Nursing and the State Board of Medical Examiners
- The legalization, manufacture, distribution, delivery, possession, and use of laetrile in Florida
- Truth in sickness legislation that would have required disclosure of ownership in any hospital or other health care facility by physicians and other health care providers
- The Surgeons Performance History Act which would have required all hospitals and ambulatory surgical centers to maintain records on all surgeons operating in the facility as to the number, type, and success rate of surgery performed within the past 10 years
- Removal of the exemption of five or less physicians from the Clinical Laboratory Act.

STANDARDIZED HEALTH CLAIM FORM — The Florida Insurance Department advised on June 5 that the new regulations implementing the standardized health claim form mandated by the 1977 legislature will become effective July 1, 1978. This form must be accepted by all insurers and the Department of Health and Rehabilitative Services. The Department, citing the specificity of the law, has ruled that no attachments will be allowed with the exception of a signature authorization. Each member of the FMA will be advised of further information as details are received which is anticipated in the immediate future.

SUMMARY OF THE FMA BOARD OF GOVERNORS MEETING
MAY 27, 1978

The FMA Board of Governors met at the Host International Hotel, Tampa, on Sunday, May 28, 1978. The following is a summary of the major actions of the Board.

FMA PRIORITIES — Adopted for Association year 1978-79 as follows:

Membership

- Intensify communication with the FMA membership, improve liaison and communications with county medical societies and Specialty Groups.
- Establishment of working relationship and improved communication with physicians in training.
- Continued strengthening of all aspects of the Continuing Medical Education Program, with special programs on nutrition and accreditation activities.
- Membership recruitment

Public

- Continued implementation of FMA medical services program with special emphasis on a nutritional program, preventive medicine, emergency medical services, and Rural Health.
- Continued efforts to implement the activities of the Florida Committee on the Cost of Medical Care in its study of the factors affecting the rise in the cost of medical services, and advising the public regarding the contributing factors.

Programs

- Further implementation of FMA Public Relations program with the news media and the general public.
- Continued emphasis on local support for legislative activities and development of a political educational program in each community, with assistance of the FMA Auxiliary.
- Increased efforts toward implementation of an effective program of evaluation and input into government programs with special emphasis on PL 93-641, National Health Planning and Development Act (HSA and the State Health Coordinating Council and administering agencies of government).
- Continued review and efforts to update third party reimbursement, specifically the Workmen's Compensation medical and surgical schedule, and the Department of HRS Schedule.
- Continued efforts to establish a statewide voluntary Professional Review Organization (PRO) without federal government control and to include the private sector (which encompasses Peer Medical Utilization Review).

Issues

- National Health Insurance
- Government interference in the practice of medicine.
- Separate Department of Health
- Role of Allied Health Professions and ancillary personnel in the delivery of health care.

Cost of Medical Care

- Directed that the Association's activities in dealing with the cost of medical care include consideration of proposed legislation requiring all rule making bodies to submit consumer cost impact studies for all legislation and rules and regulations pertaining to health care and also that FMA develop impact studies of legislation and rules and regulations affecting health care.

PRO

- Voted to include a provision for peer medical utilization review for private industry under the Association's priority dealing with PRO activities.

National Health Insurance

- Directed that the issue of national health insurance receive number one priority and that the Committee on National Legislation be requested to submit to the Board of Governors a proposed policy statement that can be used for formal testimony before congressional committees.

ANNUAL MEETING DATES — Confirmed on a definite basis proposed future annual meeting dates through 1986 and reaffirmed the previous action that all future meetings be held at the Diplomat Hotel until such time as a suitable alternate location becomes available.

*May 23-27, 1979
May 7-11, 1980
April 29-May 3, 1981
May 5-9, 1982
May 4-8, 1983
May 9-13, 1984
May 1-5, 1985
May 7-11, 1986

*Meeting dates for the 1979 annual meeting will be changed to an earlier date if possible.

HOUSE OF DELEGATES RATIO — Voted to make no change at the present time in the current ratio for the House of Delegates of one delegate to every forty members of Component County Medical Societies.

FMA AUXILIARY — Commended the FMA Auxiliary for its efforts on behalf of the medical profession and approved the proposed activities and programs of the Auxiliary for 1978-79, the theme of which will be "The Year of Awareness," including breast self-examination, cardiopulmonary resuscitation, and child abuse.

The Board requested the Auxiliary to assist in a program of physician awareness and child abuse reporting and enlisted the Auxiliary's support in the areas of legislation and public relations.

1979 LEGISLATIVE SESSION HEALTH ISSUES — Approved in principle key legislative issues affecting health to be addressed during the next session of the Florida legislature, including:

- Implementation of the constitutional provision for a separate Department of Health
- Positive initiative within private sector on cost of medical care.
- Complete review of health planning and the Certificate of Need process.
- Quality of care in state institutions.
- Improve (Revise) Medicaid program.

DOCTOR OF THE DAY PROGRAM — Adopted strict guidelines to be followed by physicians serving as doctor of the day, including in the letter of instructions that the doctor of the day not engage in any lobbying activities.

FLORIDA RELATIVE VALUE STUDIES — Authorized the Department of HRS to utilize the 1975 FMA Relative Value Studies and its 1977 supplement throughout the department for uniform coding and nomenclature.

GOVERNOR'S COUNCIL ON PHYSICAL FITNESS — Supported in principle a proposal of the Governor's Council on Physical Fitness for a program of physical fitness seminars for senior citizens and advised county medical societies of this action in the event that they may wish to participate.

SCIENTIFIC SPEAKERS REGISTRY — Approved the FMA maintaining a registry of scientific speakers to assist county medical societies, hospitals, specialty groups, and others in arranging scientific programs.

NURSE PRACTITIONERS — Requested the State Board of Medical Examiners to use the full force of their authority to take appropriate legal action against nurse practitioners whose conduct may be in violation of the medical practice act.

HOUSE OF DELEGATES ACTIONS — Received a report regarding items referred to the Board by the 1978 House of Delegates. Resolutions adopted by the House which have been submitted to the AMA at its annual meeting in St. Louis, June 17-22, include:

Relative Value Studies 78-24
Review of Governmental Health Care Programs 78-17
Blood Banking 78-14
Substandard Trained Physicians 78-12
HEW — Release of Physicians' Fees 78-6
Emergency Resolution re Patient Care 78-17

The Emergency Resolution adopted by the House of Delegates in response to President Carter's unjustified attack on the AMA was transmitted to the President by telegram.

MEDIATION PANELS — Stressed the need for individual responsibility by physicians in participating on local mediation panels to insure that the intent of this law is properly carried out.

LITIGATION — Received a report regarding the Association's subjection to interrogation of its activities by the federal government during the past several months.

IRS — A special audit of the Florida Medical Foundation (closed)
Revocation of FMA mailing permit (pending)
Federal Election Commission — Investigation of FLAMPAC activities (pending)
Federal Trade Commission — Review of FMA activities regarding restraint of trade (closed)
Justice Department — Anti-Trust investigation regarding alleged Sherman Anti-Trust violations (investigative)
IRS AUDIT — Review of FMA finances and activities (pending)

The Board was advised that in addition the FTC had instigated an investigation of the relationship between FMA and Blue Shield of Florida. It was also reported that it was anticipated that a ruling on FMA's petition for an injunction against HEW prohibiting it from releasing physicians' fees under Medicare will be made by June 6, 1978.

* * * * *

No. 258
June 27, 1978

URGENT NOTICE

STANDARDIZED HEALTH CLAIM FORM — THE 1977 FLORIDA LEGISLATURE ENACTED FS CHAPTER 77-46 REQUIRING THE DEPARTMENT OF INSURANCE TO PRESCRIBE A STANDARD HEALTH FORM TO BE USED BY ALL hospitals and a standard health claim form to be used by all **physicians** and pharmacists. These forms shall be accepted by all insurers and the Department of Health and Rehabilitative Services. (This Act does not apply to claims submitted by electronic or electro-mechanical means.)

THIS FLORIDA LAW BECAME EFFECTIVE ON JANUARY 1, 1978 AND THE REGULATIONS ARE EFFECTIVE JULY 1, 1978. THE INSURANCE DEPARTMENT HAS ADOPTED THE "HEALTH INSURANCE CLAIM FORM" approved by the American Medical Association as the form which shall be utilized for physicians' claims. A copy is enclosed.

Representatives of the FMA have requested the Insurance Department to allow attachments and to delay implementation to provide physicians adequate time to obtain the appropriate forms and to provide for an orderly transition. The Department, citing the specificity of the law, has ruled that no attachments will be allowed with the exception of a signature authorization.

THE DEPARTMENT HAS RECOGNIZED the implementation of this law without utilization of attachments may cause some physicians and their patients hardship. THE DEPARTMENT HAS AUTHORIZED A TRANSITION PERIOD UNTIL OCTOBER 1, 1978, DURING WHICH TIME ATTACHMENTS MAY BE UTILIZED TO THE STANDARD HEALTH CLAIM FORMS. After that period of time no attachments will be permitted with the exception of a signature authorization attachment where the patient's signature cannot be shown, such as in the case of a computerized operation. The Department of Insurance has indicated that a notice will be sent to companies affected by this ruling.

THE AMA "HEALTH INSURANCE CLAIM FORM" is currently available in quantities from the AMA; however, the FMA is completing arrangements for these forms to be provided on a cost basis in single copy, carbon copy, or computer form. Details will be provided when arrangements are completed.

* * * * *

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* **INDICATIONS:** Based on a review of this preparation by the National Academy of Sciences—Notionol Research Council and/or other information, FDA has classified the indications as follows: **Possibly effective:** In cutaneous candidiasis; superficial bacterial infections; the following conditions when complicated by candidal and/or bocterial infection: atopic, eczematoid, stasis, nummular, contact, or seborrheic dermatitis, neurodermatitis, and dermatitis venenata; infantile eczema; lichen simplex chronicus; and pruritus ani and pruritus vulvae.

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis; history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely establis therefore, do not use extensively on pregnant patients, in l amounts, or for prolonged periods.

PRECAUTIONS: Wotch constantly for overgrowth of nonsuscep organisms (including fungi other than candida). Should superi tion due to nonsusceptible organisms occur, administer suit concomitant antimicrobial therapy; if favorable response is not pro discontinue the preparation until adequate control by other infectives is effected. If extensive areas are treated or if the occl technique is used, the possibility exists of increased systemic ab tion of the corticosteroid; suitable precautions should be take irritation develops, discontinue the product and institute approp therapy.

ADVERSE REACTIONS: Sensitivity reactions to topical use of gram are rore. Hypersensitivity to nystatin is extremely uncommon. H sensitivity to neomycin has been reported and articles in the cu medical literature indicate an increase in its prevalence.

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Plus, because of your membership in the FMA, these plans are now available at LOW GROUP RATES due to the mass purchasing power of your association and the economies of standardized administration.

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Hospital Money Plan

This important supplemental hospital insurance protection provides benefits up to $100 per day, when you or a covered member of your family are hospitalized due to a covered accident or illness. Plus, you'll get double your benefits, up to $200 a day for intensive care treatment. And, acceptance is guaranteed to all FMA members under age 60 and their eligible family members.

Catastrophe Hospital Insurance Plan

This plan provides valuable protection against the high costs of extended hospitalization. It pays 80% of your covered hospital expenses up to a maximum of $15,000, after your deductible has been satisfied. All FMA members under 60, and eligible family members may apply. All applicants must meet the underwriting requirements of the plan.

Excess Major Medical Insurance Plan

This plan takes over where your regular medical insurance leaves off. It pays 100% of your reasonable medical expenses up to $100,000 per accident or sickness for prolonged hospitalization, after the deductible has been satisfied. Acceptance is guaranteed to all FMA members under age 60 and eligible family members.

Overhead Expense Insurance Plan

This plan provides up to $5,000 a month to help you meet your overhead office expenses when you are totally disabled due to a covered accident or illness. All FMA members under 60 are eligible to apply and will be issued coverage if they meet the underwriting requirements of the plan.

Income Protection Plan

This plan helps protect your income by providing benefits up to $1,950 a month if you can't practice medicine due to a covered accident or illness. Open to all FMA members under age 60 who meet the underwriting requirements of the plan.

Term Life Insurance Plan

Helps provide additional security for your family. FMA members may purchase coverage for this plan up to $100,000. High-limits protection is also available for your eligible family members. All applicants must meet the underwriting requirements for the plan.

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Dean's Page

Adam's Rib

Hollis G. Boren, M.D.

In all of our detailed studies of anatomic structures and in our physiologic researches into the functions of the thoracic cage perhaps we have neglected the vital role of one of Adam's ribs. We do not know which of Adam's ribs was so precious as to be selected for the creation of woman, but the event was one of immense enormity. I hope that all of us (even the MCP's) will reflect for a few moments upon the multiple contributions of women to patient care, biomedical research and medical education.

It seems to me that all too often women are passed over by such condescending cliches as "behind every great so and so is a great woman." The more magnanimous male may actually acknowledge that his wife is a vital life support system. But when we mention patient care do we think of Sir William Osler or of Florence Nightengale?

I dare say that there are many senior members of the Florida Medical Association who can remember times when there were very few or no female medical students in their classes. The few that were, were not exactly welcomed with open arms. Were they not taking the place of a fine male applicant who would practice a continuous professional life without the interruptions of pregnancies and child care? Indeed the life of these hearty early female medical students was not always pleasant. Pranks, not always in good taste, were the order of the day. Grudging acceptance to the group of male medical students was gained by guts, perseverance and superior performance.

Happily these times are past. The male medical school applicant is acknowledged to have the same responsibility to his family as does the female applicant. The number of women applicants accepted to medical school is simply a function of the size of the applicant pool and the percentage of successful applicants is the same for both men and women.

At the University of South Florida College of Medicine women medical students have consistently been approximately 18 per cent. These young ladies perform in all the disciplines starting in the basic sciences, continuing through the clinical sciences, and then through residency programs in an exemplary manner.

Only a very brave soul would suggest to one of our young ladies that she limit her career choice to a nonclinical practice. You better watch out good buddy, the next surgeon to operate on you may be on The Pill.

A very special place must be reserved for the wives of physicians. I can't be an authority on the matter but surely can imagine a monotonous, boring, duty-filled, fun scarce life of the wife of a male physician — if she let's it be. And this is the point the Women's Auxiliary of the Florida Medical Association doesn't let such nonsense happen. The Auxiliary is an active, effective, involved organization. I offer as evidence the events of the Florida Medical Association meeting in Hollywood. The three Deans of Florida's medical schools were called to the podium and were given the ever appreciated gifts provided by your contribution to the AMA-ERF fund. As we turned to leave Lou Murray said, "Wait a minute, gentlemen." To our complete surprise Mrs. R. B. (Connie) Moore stepped to the microphone and proceeded to give each medical school a check for $9,800 from the FMA Auxiliary. Thank you, ladies. I'm sure that I speak also for Will Deal and Emanuel Papper as well as myself. Once again the effectiveness of women in medicine was handsomely demonstrated.

I, for one, am glad that the goals and achievements of men and women in medicine are one, just as we are of one flesh.

Dr. Boren is Director of the University of South Florida Medical Center and Dean of the College of Medicine, Tampa.

Dr. Boren, University of South Florida, Tampa 33612.

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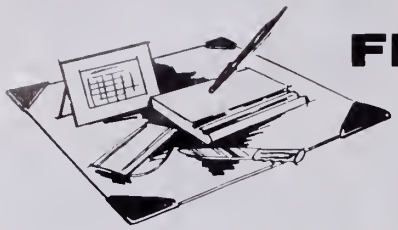
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FROM THE EDITOR'S DESK

DEFENSE COSTS

In the final days of the 1978 state legislative session, the FMA sponsored bill providing for recovery of defense costs won final passage. The bill applies to all types of civil actions, including professional liability lawsuits. It allows a defendant to recover from the plaintiff his court and legal costs if the presiding judge rules the suit was unjustified by law or fact. The new law, a major legislative triumph for the FMA in its long-range efforts to curb professional liability insurance costs, was sent to Governor Askew for signature after 65-43 passage by the House and a 37-0 vote in the Senate.

* * * * *

SEPARATE HEALTH DEPARTMENT

Florida voters will decide on November 7 whether they wish to restore the State's public health program to its rightful place through a separate department of health. The work of Florida's Constitution Revision Commission will be contained in eight proposed revisions, on which Floridians will vote separately. Provision for the department of health is contained in Ballot Proposal #1, which contains a mixed bag of other concepts such as homestead exemptions for mobile home owners and a guarantee of the right to sue the State. Creation of a separate department of health has been a major undertaking of the FMA for the past two years.

* * * * *

UNIFORM CLAIM FORM

The Florida Insurance Department advised on June 5 that the new regulations implementing the standardized health claim form mandated by the 1977 legislature will become effective July 1, 1978. This form must be accepted by all insurers and the Department of Health and Rehabilitative Services. The Department, citing the specificity of the law, has ruled that no attachments will be allowed with the exception of a signature authorization. Each member of the FMA will be advised of further information as details are received which is anticipated in the immediate future.

BLUE SHIELD

The FMA Board of Governors has been advised that the Federal Trade Commission has instigated an investigation of the relationship between FMA and Blue Shield of Florida. In a related national development, Department of HEW lawyers will investigate charges that physician control of Blue Shield boards may contribute to inflation in physicians' fees. "The use of organizations whose policy-making boards are dominated by physicians as (government) fiscal agents to pay physicians may raise serious questions of conflict of interest," HEW Secretary Joseph Califano told newsmen.

* * * * *

SECOND OPINIONS

The American College of Surgeons has branded as "ill-advised and premature" the Department of HEW's program to stimulate second opinions for surgery under the Medicaid and Medicare programs. "The ultimate economy in use of surgical therapy might be achieved by enlisting faith healers to provide second opinions," ACS Director C. Rollins Hanlon quipped. Two HEW-funded demonstration projects to test the value of second opinion programs are getting under way this year. HEW sees it as an anti-inflation device. FMA's Board of Governors, at its most recent meeting, turned down a request from the Department of HEW that FMA participate in this program.

* * * * *

PUBLIC DOCUMENTS

A federal judge in Washington has ruled that Professional Standard Review Organizations (PSRO) documents are public records that may be obtained under the Freedom of Information Act. U.S. District Judge Gerhard Gesell ruled in a suit brought by Ralph Nader's Public Citizen Health Research Group, which sued to obtain PSRO records. The PSRO argued that it is a consultant to the Department of HEW. However, Judge Gesell held that the crucial role played by the

PSRO in the public health process makes it a public agency subject to disclosure. The Nader group sought all the PSRO's records except those involving identifiable names of patients.

* * * * *

SUNSET

The AMA has told Congress it supports the concept of subjecting all federal programs to review and budget reauthorization at least once every six years. In a letter to the Committee on Rules and Administration, AMA said Congress needs "to untangle the bureaucratic web which appears to be trapping every American citizen." The Sunset Act of 1977 (S2) would create a Citizen's Commission on Organization and Operation of Government to review federal progrms and agencies and make recommendations for reform.

* * * * *

MISMANAGMENT

A report of a subcommittee of the Senate Governmental Affairs Committee charges that California's prepaid health plan program has been "seriously mismanaged and grossly abused." Sen. Sam Nunn of Georgia said he would not vote for the $500 million five-year extension of the Health Maintenance Organization (HMO) program until there is response to the "problems which have been identified." Nunn is Vice Chairman of the Subcommittee on Permanent Investigations. The Subcommittee's report said the Department of HEW was "lax in its oversight over federal Medicaid funds spent in the California program over a period of years."

* * * * *

GLASS HOUSES

The Cincinnati Enquirer says, in effect, that people who live in glass houses shouldn't throw stones. The newspaper shared the Department of HEW's concern about the cost of hospital care. But, the newspaper added, Secretary Califano ought to look to "his own back yard where the cost of government is rising faster than anything he can criticize."

* * * * *

MISMANAGEMENT

A government report indicates the Department of HEW frittered away about $7 billion in fiscal 1977. The Office of the Inspector General attributes most of this to waste and mismanagement as opposed to fraud and abuse. "Rough and incomplete," HEW Secretary Joseph Califano said of the figures.

* * * * *

1974 HEALTH PLANNING LAW

The U.S. Supreme Court has upheld the constitutionality of the 1974 Health Planning Law. A North Carolina federal court had ruled that way last year, and the case was appealed to Washington by the AMA, the states of Nebraska and North Carolina and the North Carolina Medical Society. They maintained that the law's requirement that states pass certificate-of-need laws before receiving federal grants was an unconstitutional violation of state's rights. The Supreme Court upheld the lower court without an opinion.

* * * * *

COST CONTAINMENT

Some 7,000 hospital medical staff chiefs have been urged to adopt resolutions supporting the national Voluntary Cost Containment Program. The AMA, the American Hospital Association and the Federation of American Hospitals organized the program last year. The goal is to reduce hospital revenue increases by 2 per cent a year over the next two years.

* * * * *

VOTE POSTPONED

The U.S. House of Representatives has postponed indefinitely a vote on legislation to extend coverage of the National Labor Relations Act to interns and residents. A vote had been scheduled for May 4 on HR 2222, but new indications of administration opposition and the occurrence of physicians' strikes led the floor leaders to delay the vote.

* * * * *

MENTAL HEALTH

The President's Commission on Mental Health recommends a $600 million increase in federal funding over a five-year period for mental health services and research. The Commission said it believes "a national health insurance program which includes appropriate coverage for mental health care offers the most effective means of providing adequate financing."

PEDIATRIC SUBSPECIALTIES

The subspecialties of pediatric nephrology and pediatric endocrinology have been approved for inclusion in the AMA's list of recognized specialties. The new additions — proposed by the American Board of Pediatrics — extend the list to 74 specialties and subspecialties.

* * * * *

MARIJUANA

The AMA advocates expanded research on the medical uses of two marijuana derivatives — tetrahydrocannabinol and cannabidiol. However, neither substance should be reclassified on controlled substances schedules at this time. The AMA statement came in response to a reported White House initiative to persuade the National Cancer Institute to make the ingredients available to alleviate the side effects of cancer chemotherapy.

* * * * *

AMA-ERF GRANTS

State medical associations have received this year a total of $1.5 million in AMA-ERF unrestricted grants for presentation to the nation's medical school deans. The money came from contributions of physicians and medical societies, fund-raising efforts of medical society auxiliaries and donations from others interested in medical education.

* * * * *

PRACTICE OPPORTUNITIES

More than 4,000 practice opportunities are listed in the April edition of the AMA's *Opportunity Directory*. Copies of this publication and of *Directory of Physicians Seeking New Positions* are available from the AMA Physicians' Placement Service in Chicago.

The Editor

Register To Vote!

Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

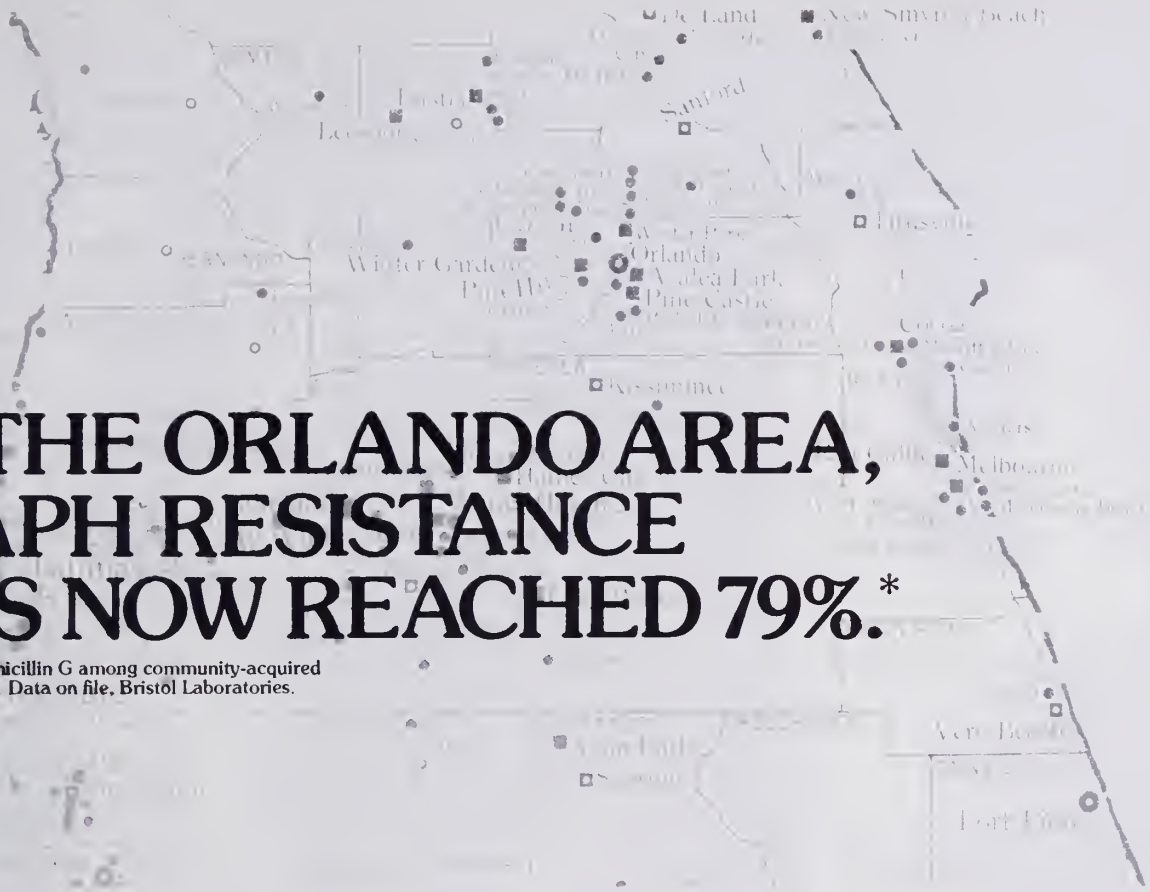
Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

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(cloxacillin sodium)

..."THE PENICILLIN OF TODAY"

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.
- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



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And, of course, that's a major dietary concern.

But you can also have too little of a good thing. Especially, milk. Milk supplies more essential nutrients per calorie than most other foods.

A child between the ages of six months and six years, for example, can get at least three-fourths of his daily dietary allowance for calcium, riboflavin, vitamins D and B_{12}, phosphorus, and protein from just three glasses of milk. And milk is also a good source of vitamins A and B_6, as well as thiamin and niacin.

That's why the U.S.D.A., acting on the recommendation of the National Research Council—National Academy of Sciences, has established these guidelines for milk consumption:

Children up to 6 years
Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

Per cent of Recommended Daily Allowanc contributed by three 8 oz. glasses of fortifie milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yr
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on: 60 mg tryptophan=1 mg niacin

ndc **National Dairy Council**

Milk. Sometimes we forget all the good things it does.

JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION INC
JULY 1978 • VOL 65 • NO 7

Florida Medical Association House of Delegates

Proceedings

One Hundred Fourth Annual Meeting — Florida Medical Association, Inc.

Hollywood, May 3-7, 1978

President's Address

Louis C. Murray, M.D.

This meeting of the House of Delegates brings us to the close of another year of service by the Florida Medical Association, to its members, and to the people of this great state. Our activities have been many and varied, but always with one goal in mind — the preservation and advancement of the finest system of medical care this world has ever known.



FMA President Louis C. Murray, M.D., addresses the First Session of the House of Delegates.

Today our Association is strong, healthy and vibrant and it has the support and dedication of its entire membership. During the past year as President of this fine organization, I have worked with and observed your Association, and I have the utmost confidence in its ability to do the job. We have an organization which has benefited from the thousands and thousands of hours of work and dedication of many of its members. As you deliberate the activities of your Association reported in the Delegate's Handbook, you will fully realize that the FMA and its Councils and Committees have struggled with some of the most pressing and crucial issues facing our profession. Such issues as: the incessant interference in the private practice of medicine by government at all levels; health planning, including federal health planning mandates, HSA activities and specifically, rural health; rate review and regulations; relicensure; threats to professional and individual rights to privacy and the preservation of free enterprise; quantitative medical care delivery with little or no regard to quality; non-professional nor qualified regulations affecting the practice of medicine. The list goes on and on and on.

Among other things, our top priorities for this year were developed to concentrate in the following areas: membership, programs, public and legislative activities.

Our efforts in the field of membership were simple yet specific. We worked to continue and intensify the information program for county medical societies and the membership in general. Similarly, we continued to strengthen all aspects of the continuing medical education program and accelerate accreditation activities. At the same time, we improved our liaison and coordination with county medical society officers, staffs and specialty groups.

As far as the public is concerned, we have continued to work toward implementation of medical service programs aimed at providing the highest quality medical care for all Floridians, regardless of geographical location or socio-economic status. Special emphasis has been placed on emergency medical services. The Association has placed a high priority on the development and operation of an efficient and all encompassing emergency medical service to assure the availability of an acceptable minimum level of care throughout the state on a first priority basis for our citizens. We encourage a statewide system of EMS communication networks and coordination of health care facilities to carry out this responsibility.

FMA has also concentrated its efforts on analysis and implementation of an effective program to deal with the continuing rise in the cost of health care and in so doing, to insure that neither the quality of health care nor the integrity of our profession and our patients is jeopardized.

Recognizing the mounting national concern over rising health care costs, the FMA has established the Florida Committee on the Cost of Medical Care, a broad-based committee comprised of representatives from the FMA, Florida Hospital Association, Blue Cross-Blue Shield, the Florida State Health Insurance Association, industry and labor.

The reasons for cost escalation are many and complex. The prime cause is the interference and participation of the federal government at all levels in the health care process, and is almost an uncontrollable one. The greatest degree of attention will be given to the areas of potential cost control within the purview of the committee's structure.

A number of existing and proposed programs were designated as priority items for this year. Included among these was the continued implementation of the FMA public relations programs for members and the general public. Our public relations activities this past year have been widespread, involving the production of two major films, shown throughout the state, on the quality of medical care and practical preventive medicine. Because of the vital importance of our public relations activities, I have asked Dr. Vernon Astler, Past President and our current Public Relations Officer, to make a special report to this House of Delegates summarizing our public relations activities and accomplishments this past year and our future goals. His report will address such things as our public service announcements, radio-TV presentations, including our two special film productions, our Speakers Bureau and other important segments of the PR program all of which have touched the lives and health care interests of many thousands of Floridians.

As physicians we recognize the vital importance of our interest and involvement in the governmental process at all levels. This is essential to preserving our profession. During this past year, we have placed more emphasis on the development and expansion of indepth, grassroots support for legislative educational activities. We are also cognizant of the important role of PAC activities at the national, state and local level in ensuring continuation of the current free enterprise system of medical care.

Major objectives of your FMA are to promote the science and art of medicine and the betterment of public health, to strive for the enactment, preservation and enforcement of just medical and public health laws. We have truly dedicated our resources toward that end and many physicians from all areas of the state have spent countless hours in working to achieve these worthy objectives. In its report to the House, included in your Delegate's Handbook, your Board of Governors summarizes efforts that have been made to restore a vital and viable Department of Health in the State of Florida. As most of you know, the dedicated efforts of many physicians and other concerned citizens have had gratifying results for the people of Florida in that the Constitution Revision Commission has recommended a constitutional provision for a separate Department of Health. The contributions of Dr. Edward R. Annis, a member of the Commission, in earning the overwhelming support of his fellow commissioners for a separate Department of Health are immeasurable. His articulate and factual presentations on Florida's past performance as a leader in public health programs and services measured against the continuing deterioration in health services brought about by governmental reorganization in Florida was convincing testimony to reestablish a separate Department of Health and a great victory for the citizens of Florida.

Implementing legislation for this separate Department of Health will be a top priority in the Association's 1979 legislative program.

Far too long have those programs having to do with health care, such as our county health departments, Medicaid program, children's medical services, mental health and comprehensive health planning been under the administration and control of bureaucrats without

proper professional medical input. When you think of the bureaucratic maze of the Department of HRS, with the eleven integrated districts, capped by a cloud of bureaucracy in Tallahassee, with a budget of $1,200,000,000 per year — you are prone to realize that this is the same innovative type structure that has resulted in the problems faced in health by Great Britain today. Health matters have been treated as a second class citizen, with a second class budget. The top health professional in the Department has been relegated to a fifth echelon administrative post, with no policy input whatsoever. I assure you that if this article of the Constitution Revision Commission passes — we shall see a new day in providing for the public health of all Floridians.

My trip to England last May, to attend the National Health Seminar in London, only strengthened the resolve, (developed last year by Dr. MaCris as a result of his trip), that we must continue to devote our expertise and our energies to prevent the same inefficient and ineffective health care delivery system from becoming a reality here in this country. I saw the same ill-equipped hospitals, the same over-utilization of all manner of health care facilities, as Dr. MaCris did. I saw an apathetic attitude on the part of the British citizens and also on the part of the British physician (both the clinic and office based generalist and the hospital based consultant). The younger physician yearns to leave, and many have — over 25% of those completing training each year. The void of emptiness left by the emigration of these young English physicians to other parts of the world has been filled by non-English speaking physicians coming in from other lands under loose immigration laws and immigration quotas to try to fill the gap.

The older established physician just shrugs his shoulders and resigns himself to spending over 50% of his productive time fighting the battle of consumer dominated local health advisory committees, who have the power of recommending to the area health committees, then on to the regional health authorities, in the area of health administration and budget, and on to the Secretary of State to make the final decision. Cost containment has gone out the window in Britain, with too many overpaid administrators, and too many tiers of authority. All of this, coupled with trade unionization infiltrating all areas of the National Health Service, has resulted in the most expensive, and most inefficient health care system in a modern Western nation today.

Many, if not all of these things are ready to happen here in this country, dependent on what direction our national and state, legislators and regulatory agencies take in the future.

The FMA has always been, still is, and will always be committed to the availability of medical care for all citizens regardless of socioeconomic status. The quality of ambulatory and institutional care provided through Medicaid should be on a par with that provided for the rest of our citizens, and funding for such should be realistic, oriented toward ambulatory care and in accordance with public accountability of expenditures. This can be done through the free enterprise system — devoid of bureaucratic overtones.

The establishment of FMA field offices in South and Central Florida is one of the areas that I am most proud of. The primary function of these branch offices and the Capital Office in Tallahassee is to develop an in-depth and integrated program for legislative educational and public relations activities, to enhance effective communications with the media, and in order to provide better liaison and coordination of activities between FMA and its component county medical societies and its members.

Other issues of prime importance this past year include national health insurance, professional liability legislation, with particular emphasis on the recovery of defense costs.

The Association has been very active in the national legislative scene during the past year. Your officers, Board of Governors, key legislative contact physicians and FMA staff have been deeply concerned about not only the possibility of national health insurance, but with the problems associated with Public Law 93-641 (Health Manpower Act), which created the system of HSA's (or Health System Agencies) across the country. All nine HSA areas have now been designated in Florida.

The development of in-depth regular discussions with Congressman Paul Rogers has enabled the Association to gain his support for deleting the requirement for certificate of need for physicians' offices from the House version of the cost containment bill.

The FMA has supported amendments to Public Law 93-641 to remove adverse provisions of the law and make it more workable. Your Association also recommended amendments to the national health planning guidelines to provide for: national guidelines from HEW be only advisory — not mandatory; health planning should be determined at the local level not mandated by federal or state government; to eliminate classification of indirect provider, and designate providers as those involved with direct health care of our people; and VA hospitals and all government facilities should be covered under the act instead of receiving special privileges. Government facilities should receive no more nor less consideration than the private sector.

This year your Association has given strong support to efforts to increase the appropriations to the Board of Medical Examiners, in order that additional legal staff and investigators may be employed to carry out the

provisions of the act so necessary to keep professional conduct standards high, and root out fraud, abuse and bad medical practice wherever and whenever it is found to exist.

Your Association has taken aggressive action toward protecting the rights and privacy of the physician-patient relationship by initiating a suit in federal court against the Secretary of HEW, seeking an injunction preventing the Secretary from the arbitrary and unwarranted release of Medicare payments to physicians for both assigned and unassigned claims, indicating the names and addresses of all physicians and patients involved. This information serves no useful purpose, but violates the constitutional rights of both physician and patient under the 1st, 4th, 5th, and 14th Constitutional amendments and the Freedom of Information Act of 1974. I am pleased to report to you that just a few days ago, on April 28, 1978, U.S. District Court Judge Charles R. Scott issued a temporary restraining order against the Department of Health, Education and Welfare, and its Secretary Joseph A. Califano; Blue Shield of Florida, Inc.; and Group Health of Miami preventing release and public disclosure of any information related to Medicare payments made directly to physicians or to their patients.

We will continue efforts to achieve a permanent injunction prohibiting HEW from carrying out this totally unjustified and capricious regulation.

As I stated in my preamble to the report of your Board of Governors, I am deeply honored for having had the opportunity to serve the FMA during this past year. It is without question the mirror of the ideals and high standards of professional excellence and integrity of its almost 12,000 members.

As I leave this office, it is with deep appreciation that what successes have occurred have only occurred through the able assistance of our Board of Governors, Committees, Council Chairmen, the fine FMA staff and, most of all, the support of this entire membership.

The problems we face today are indeed many and complex. However, I am confident in our ability as a united FMA to cope with any challenge. To me, the clouds on the horizon are many, but beyond the future is bright. We have the past experience, capability and above all the total and tenacious dedication to do what is right, to insure our tomorrows. It's up to us — so let's do it!



Nineteen of the Association's Past Presidents gathered for their traditional breakfast on Friday of the Annual Meeting. Seated: Dr. George S. Palmer, Tallahassee (1966); Dr. Samuel M. Day, Jacksonville (1964); Dr. Leo M. Wachtel, Jacksonville (1960); Dr. Jere W. Annis, Lakeland (1958); Dr. Walter C. Jones, Miami (1941); Dr. William C. Roberts, Panama City (1957); Dr. Ralph W. Jack, Miami (1959); Dr. Warren W. Quillian, Coral Gables (1963); and Dr. H. Phillip Hampton, Tampa (1965). Standing: Dr. Jack A. MaCris, St. Petersburg (1976); Dr. Vernon B. Astler, Boynton Beach (1975); Dr. Thad Moseley, Jacksonville (1974); Dr. Joseph C. Von Thron, Cocoa Beach (1973); Dr. William J. Dean, St. Petersburg (1972); Dr. Floyd K. Hurt, Jacksonville (1971); Dr. James T. Cook, Marianna (1970); Dr. Henry J. Babers Jr., Gainesville (1969); Dr. Jack Q. Cleveland, Coral Gables (1968); and Dr. W. Dean Steward, Marianna (1967).

First House of Delegates

The First House of Delegates convened at 4:30 p.m. on Wednesday, May 3, 1978, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with Charles J. Kahn, M.D., Speaker of the House, presiding.

The invocation was given by W. Dean Steward, M.D., Past President.

Dr. John Glotfelty, Chairman of the Credentials Committee, reported that a quorum of 201 delegates were present and that enough counties were represented to constitute a quorum. Dr. Glotfelty moved that the delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; William B. Deal, M.D.; James C. Garlington, M.D.; Douglas O. Jenkins, M.D.; William W. Pfaff, M.D.; Gerold Schiebler, M.D.; James Campbell, Student Delegate

BAY — Philip Cotton, M.D.; James D. Nixon, M.D.

BREVARD — Edwin E. Hadden, M.D.; Laudie E. McHenry, M.D.; Howard W. Pettengill, M.D.; Burton Podnos, M.D.; (Absent — Richard Baney, M.D., Brian P. Gibbons, M.D.)

BROWARD — Charles M. Bonura, M.D.; Andre S. Capi, M.D.; Phillip A. Caruso, M.D.; Burns A. Dobbins, M.D.; Arthur L. Eberly, M.D.; Theodore W. Hahn, M.D.; William C. Hartley, M.D.; James B. Perry, M.D.; Thomas F. Regan, M.D.; Joseph M. Sachs, M.D.; Ernest G. Sayfie, M.D.; Norbert Skaja, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; Juan S. A. Wester, M.D.; (Absent — Robert L. Andreae, M.D.; Charles H. Bechert, II, M.D.; Robert J. Brennan, M.D.; Bruce B. Burgess, M.D.; Russell B. Carson, M.D.; Milton P. Caster, M.D.; Willis N. Dickens, M.D.; Richard S. Doyle, M.D.; F. Gary Gieseke, M.D.; David C. Lane, M.D.; George P. Messenger, M.D.; Floyd Osterman, M.D.; Raymond E. Parks, M.D.; Diran Seropian, M.D.)

CAPITAL — Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Robert N. Webster, M.D.

CHARLOTTE — (Absent — Thomas R. Civitella, M.D.; Melvyn J. Katzen, M.D.)

CITRUS-HERNANDO — James J. Cuffe, M.D., W. Randall Jenkins, M.D.

CLAY — Laurin G. Smith, M.D.

COLLIER — Virgil A. Ponzoli Jr., M.D., Donald Q. Vining, M.D.; Robert J. Wald, M.D.

COLUMBIA — Henry E. Plenge, M.D.

DADE — Robert L. Bishany, M.D.; Leo Braverman, M.D.; Manuel L. Carbonell, M.D.; Luis A. Cabrera, M.D.; Sol Center, M.D.; Richard C. Clay, M.D.; Jack Q. Cleveland, M.D.; Vincent P. Corso, M.D.; Victor Dabby, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Diane B. Eisman, M.D.; Franklin J. Evans, M.D.; Miguel Figueroa, M.D.; George R. Gage, M.D.; Stephen H. Glucroft, M.D.; L. Marshall Goldstein,



Charles J. Kahn, M.D., Speaker of the House of Delegates, presides at a House session. Left to right: President-Elect O. William Davenport, M.D.; President Louis C. Murray, M.D.; Executive Vice President W. Harold Parham, D.H.A.; Dr. Kahn; Vice Speaker Sanford A. Mullen, M.D.; Vice President J. Lee Dockery, M.D.; Secretary Robert E. Windom, M.D.; Treasurer Richard S. Hodes, M.D.; and Immediate Past President Jack A. MaCris, M.D.

M.D.; Max E. Gomez, M.D.; Norman Gottlieb, M.D.; Alan S. Graubert, M.D.; Maurice Greenfield, M.D.; Leo Grossman, M.D.; Joseph Harris, M.D.; Marvin L. Jaffee, M.D.; Walter C. Jones III, M.D.; James R. Jude, M.D.; Norman M. Kenyon, M.D.; Maurice H. Laszlo, M.D.; Ildefonso Rafael Mas, M.D.; Joseph T. Ostroski, M.D., Raul Rivet, M.D.; Milton S. Ross, M.D.; Everett Shocket, M.D.; William M. Straight, M.D.; Chauncey M. Stone, M.D.; Charles F. Tate, M.D.; John Turner, M.D.; Edgar W. Webb, M.D.; Sheldon Zane, M.D.; (Absent — Edward Annis, M.D.; Seymour Alterman, M.D.; Jose S. Bocles, M.D.; Rufus K. Broadaway, M.D.; John E. Cunio, M.D.; Eduardo E. Delgado, M.D.; Robert W. Elkins, M.D.; Ivor Fix, M.D.; Eugene Flipse, M.D.; Richard L. Glatzer, M.D.; Pedro J. Greer, M.D.; Julian H. Groff, M.D.; Henry C. Hardin, M.D.; Marshall Hall, M.D.; Robert B. Katims, M.D.; Banning G. Lary, M.D.; Martin E. Liebling, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Victor A. Politano, M.D.; Arvey I. Rogers, M.D.; Walter M. Sackett, M.D.; Edward W. St. Mary, M.D.; Janice K. Sherwood, M.D.; David Sims, M.D.; Samuel P. Stokley, M.D.; Shreve Archer, Student Delegate)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Warren M. Barrett, M.D.; William P. Booras, M.D.; Doris N. Carson, M.D.; Yank D. Coble, M.D.; Patricia Cowdery, M.D.; Wilbert L. Dawkins, M.D.; Charles P. Hayes Jr., M.D.; John C. Kruse, M.D.; Charles B. McIntosh, M.D.; Daniel B. Nunn, M.D.; John A. Rush, M.D.; Guy T. Selander, M.D.; William D. Walkett, M.D.; (Absent — Samuel J. Alford Jr., M.D.; H. Joseph Hurlbut, M.D.; Robert Middlekauff, M.D.; B. Craig Ray Jr., M.D.; Robert H. Threlkel, M.D.)

ESCAMBIA — George L. Carr, M.D.; Eric F. Geiger, M.D.; Charles F. McConnell, M.D.; Henry M. Yonge, M.D.; Robert K. Wilson, M.D.; (Absent — Kenneth I. Holman, M.D.)

FRANKLIN-GULF — Joseph P. Hendrix, M.D.

HIGHLANDS — Glenn V. Hough, M.D.; Robert T. Rengarts, M.D.

HILLSBOROUGH — Richard A. Bagby, M.D.; Louis E. Cimino, M.D.; Francis C. Coleman, M.D.; Robert J. Courtney, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Richard S. Hodes, M.D.; Victor H. Knight Jr., M.D.; Joel W. Mattison, M.D.; John K. Petrakis, M.D.; Ronald L. Seeley, M.D.; Ralph M. Stephan, M.D.; William W. Trice, M.D.; Harold L. Williamson, M.D.; Henry P. Freider, Student Delegate; (Absent — Richard G. Connar, M.D.; Thomas E. McKell, M.D.; Woody N. York, M.D.)

INDIAN RIVER — (Absent — Donald L. Ames, M.D.; Ferdinand F. Becker, M.D.)

LAKE — Frederick C. Andrews, M.D.; James M. Hardy, M.D.; Thomas D. Weaver, M.D.

LEE — Larry P. Garrett, M.D.; John S. Hagen, M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr., M.D.; Marcus M. Moore, M.D.

MADISON — (Absent — William J. Bibb, M.D.)

MANATEE — Thomas R. Busard, M.D.; Sanford Elton, M.D.; John D. Lehman, M.D.; Roger Meyer, M.D.

MARION — C. Brooks Henderson, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; Richard Q. Penick, M.D.

MONROE — (Absent — Ronald H. Chase, M.D.; Robert P. Kaminsky, M.D.)

NASSAU — (Absent — Jose L. Castillo, M.D.)

OKALOOSA — Eugene R. Valentine, M.D.; (Absent — William W. Thompson, M.D.)

ORANGE — Clarence H. Brown, M.D.; Manuel J. Coto, M.D.; Sam F. Elder, M.D.; Clarence M. Gilbert, M.D.; Dorothy T. Lloyd, M.D.; Donald V. Jablonski, M.D.; David L. Mackey, M.D.; Franklin B. McKechnie, M.D.; Hector R. Mendez, M.D.; Robert A. Metzger, M.D.; James F. Richards Jr., M.D.; James J. Schoeck, M.D.; Edward W. Stoner, M.D.; T. Byron Thames, M.D.; (Absent — Stephan A. Butler, M.D.; Robert B. Trumbo, M.D.)

OSCEOLA — George A. Gant, M.D.

PALM BEACH — Vernon B. Astler, M.D.; John D. Corbitt Jr., M.D.; Lee Fischer, M.D.; James R. Forlaw, M.D.; Luis R. Guerrero, M.D.; V. A. Marks, M.D.; Charles E. Metzger, M.D.; Benjamin Moore, M.D.; Roger D. Petersen, M.D.; Reginald J. Stambaugh, M.D.; Arthur L. Trask, M.D.; Dick L. Van Eldik, M.D.; (Absent — Thomas E. Murphy, M.D.; Harold A. Yount, M.D.)

PANHANDLE — Herbert E. Brooks, M.D.; (Absent — William F. Brunner, M.D.)

PASCO — Nessan McCann, M.D.; (Absent — Morris L. Saperstein, M.D.)

PINELLAS — Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Kay Knight Hanley, M.D.; Morris J. LeVine, M.D.; Jack A. MaCris, M.D.; William F. Mallette, M.D.; James H. Miller, M.D.; Donald G. Nikolaus, M.D.; Frederick O. Smith, M.D.; David T. Overbey, M.D.; (Absent — James C. Fleming, M.D.; John M. Hamilton, M.D.; David S. Hubbell, M.D.; Frank I. Mendelblatt, M.D.; James M. Neill, M.D.; Walter H. Winchester, M.D.)

POLK — Salvadore J. Barranco, M.D.; Thomas M. Caswall, M.D.; Frank J. Fischer, M.D.; Clyde E. Gibson, M.D.; John W. Glotfelty, M.D.; Wiley E. Koon, M.D.; Stanley W. Lipinski, M.D.; Paul A. Tanner Jr., M.D.

PUTNAM — (Absent — Roy E. Campbell, M.D.)

ST. JOHNS — Constantine Antonatos, M.D.; Reuben J. Plant, M.D.

ST. LUCIE-OKEECHOBEE — Bruce E. Mills, M.D.; (Absent — William H. Meyer Jr., M.D.)

SANTA ROSA — (Absent — William N. Watson, M.D.)

SARASOTA — John N. Carlson, M.D.; Kenneth C. Keihl, M.D.; Samuel E. Kaplan, M.D.; Franklin Pfeiffenberger, M.D.; Richard Rehmeyer, M.D.; Karl R. Rolls, M.D.; (Absent — Martin F. Mihm, M.D.)

SEMINOLE — Luis M. Perez, M.D.; Frederick J. Weigand, M.D.

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Laurent V. Radkins, M.D.)

TAYLOR — John H. Parker, M.D.

VOLUSIA — Richard L. Dillard, M.D.; Irwin Leider, M.D.; Frank J. Lill, M.D.; Alvin E. Smith, M.D.; Charles A. Stump, M.D.; James G. White, M.D.

WALTON — Thomas G. Spence, M.D.

SPEAKER OF THE HOUSE — Charles J. Kahn, M.D.

VICE SPEAKER — Sanford A. Mullen, M.D.

Upon motion duly carried, the Rules and Order of Business of the House were adopted as follows:

Information for Delegates

The Rules and Order of Business for the House of Delegates is included in this handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. Our By-Laws do not permit an alternate to serve for a delegate who has once been seated. The By-Laws require that delegates fill out attendance cards at **each meeting** of the House of Delegates in order to be credited in attendance, and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Reports and resolutions that were received before going to press are included in this Handbook. Delegates are urged to study them carefully before they are introduced in the House. Wherever possible it is requested that resolutions and supplemental reports be forwarded

to the Association's executive office by April 27 for duplication and distribution to the delegates.

Your attention is called to the format of the annual meeting, where the Reference Committee meetings will be held in the morning following the First Meeting of the House. All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairman to defer items in which they are interested in order that they may be present to discuss the subject.

All resolutions **must have a sponsor present** before the Reference Committee. Resolutions must be filed by 12:00 noon on the day of the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be available for distribution by the time the First House convenes. Only the "Resolved" portion of resolutions will be adopted as policy.

All Reference Committee reports will be duplicated and available to the delegates at the Registration Desk on Saturday morning. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, those which will be in the Delegates' Packets, and the reports of the Reference Committees have been printed on colored paper for easy reference. This color code is as follows:

Reference Committee No. I — Green
Reference Committee No. II — Buff
Reference Committee No. III — Blue
Reference Committee No. IV — Pink
Reference Committee No. V — Goldenrod

According to our By-Laws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

Charles J. Kahn, M.D., Speaker
House of Delegates
Sanford A. Mullen, M.D., Vice Speaker
House of Delegates

A motion carried to adopt the minutes of the 1977 House of Delegates as published in the July 1977 issue of *The Journal of the Florida Medical Association.*

Dr. Kahn, Speaker, advised that during the past year a number of FMA members had departed this life. In memory of these physicians, roses had been placed in the vases at each end of the Speaker's podium. Dr. Kahn asked that the House observe a moment of silent prayer in respect and memory of these members.

The Speaker introduced the officers of the Association: Drs. Sanford A. Mullen, Vice-Speaker; Louis C. Murray, President; O. William Davenport, President-Elect; Jack A. MaCris, Immediate Past President; J. Lee Dockery, Vice-President; Robert E. Windom, Secretary; Richard S. Hodes, Treasurer; and W. Harold Parham, D.H.A., Executive Vice President.

The Speaker then instructed the House.

Remarks — Speaker of the House

Mr. President, Officers of the FMA, Honored Guests and Fellow Delegates, it is my pleasure to welcome you to the 1978 Annual Meeting of the House of Delegates. On behalf of the members of the FMA, thank you for being here.

Organized medicine has two primary functions: to insure the availability of quality medical care and to provide an atmosphere for the practice of medicine which promotes personal and intellectual gratification and economic stability. These are our purposes in being here today. Certainly, it would be presumptious to believe we could solve, in these few days, the monumental problems which face us today, but we can make progress, however small, if we use the tremendous talent and store of information available in this House. Your participation and knowledge are sorely needed in reference committee hearings and deliberations on the floor of the House.

The procedures for conducting the business of the House are summarized in your handbooks. Your Vice-Speaker and I are here to help. Call on us at any time for any questions that may arise. We are most desirous of having all here feel that all matters have been decided in an equitable and democratic manner. If you should question the propriety of the proceedings, please make your question known from the floor at the time. If you disagree with a ruling, you have the right to appeal from the ruling of the chair. It is essential that we all leave here with a unified approach to our problems regardless of differing positions on specific issues, for divisiveness serves only to move us farther from our goals. May we always have the wisdom to temper our zeal with respect for the opinions of others.

Thank you.

The remarks of the Speaker of the House of Delegates were referred to Reference Committee No. III for consideration.

Dr. Kahn introduced Mrs. Richard B. Moore, President, Florida Medical Association Auxiliary; Mrs. T. Byron Thames, President-Elect, Florida Medical Association Auxiliary; Edward R. Annis, M.D., Past President AMA; Jere W. Annis, M.D., Lakeland, AMA Board of Trustees; James W. Walker, M.D., Past Officer of FMA and President, PIMCO; E. Charlton Prather, M.D., Director, Division of Health, Tallahassee; Mr. Jack W. Herbert, President, Blue Shield of Florida, Jacksonville; Howard E. Hill, AMA Delegate, Virgin Islands; and Luis M. Perez, M.D., Sanford, recipient of the 1977 AMA Benjamin Rush Award.

Mrs. Moore was invited to make a few remarks.

Mrs. Moore summarized the accomplishments of the Auxiliary during the past year. She stated that the theme for the year for the Auxiliary had been "Reach Out



James T. Cook Jr., M.D., of Marianna, (right) presents the A. H. Robins Company Award for Outstanding Community Service by a Physician, to another Marianna doctor, Richard H. Schulz, M.D.

and Touch." Mrs. Moore stressed that all must work together to achieve the goals of the Association.

Dr. Kahn requested Dr. James T. Cook Jr., to come to the platform to present the A. H. Robins Award for "Outstanding Community Service by a Physician." Dr. Cook requested Dr. Herbert Brooks to escort Dr. Richard H. Schulz, Marianna, to the podium to receive the award. A. H. Robins Company representative, Mr. Tony Martinez, was present for the presentation.

A. H. Robins Company Award For Outstanding Community Service By A Physician

Richard H. Schulz, M.D., of Marianna, Florida, who has dedicated his professional and personal life to helping ill, disadvantaged and mentally impaired children through civic activities and the faithful practice of medicine, has been elected to receive the 1978 A. H. Robins Company Award for Outstanding Community Service by a Florida Physician.

Each year the Board of Governors faces the difficult task of singling out a member of the Florida Medical Association for this honor from nominees proposed from FMA's county medical societies. Recipients are selected on the basis of services rendered to their communities.

A mere glance at the long list of Dr. Schulz's activities and accomplishments leaves no doubt that he has given generously of himself to his profession and to the improvement and social well-being of his Florida home.

Born in Winter Haven, 54 years ago, Richard Hugh Schulz developed a love for wildlife living next door to nationally known herpetologist Ross Allen. After graduation from the University of Florida, he entered Emory University School of Medicine where he met his future wife, Dr. Sarah Malone Schulz, and was awarded an M.D. degree.

The doctors Schulz moved to Marianna in 1952, and have since been deeply engrossed in every phase of community life.

As a physician, Dr. Schulz served for several years as Secretary-Treasurer of the Panhandle Medical Society, and is currently President of the Society. He has also served on most committees and is past-Chief of Staff of Jackson Hospital.

In 1969, at the time of the Biafran conflict, the Doctors Schulz went to Africa and served for three months on the Ivory Coast caring for Biafran children.

A staunch defender of Florida's outdoor heritage, Dr. Schulz served six years as the Northwest Florida representative to the Florida Fresh Water Fish and Game Commission. Dr. Schulz combines his affection for wildlife and his devotion to children with regular outings to his farm. Together with his eight children, Dr. Schulz often entertains children from nearby Sunland Center at the farm, which is home for ostriches, camels, sheep, goats, horses, llamas, deer, lions and other forms of wild and domestic animals.

Dr. Schulz has served as President of the Marianna Rotary Club, and the Parent Teacher Association, and as a member of the City Commission. He has served as County Chairman of the Republican Party, and served on the State Republican Committee, and chaired the Committee for the Legal Control of Alcoholic Beverages.

Dr. Schulz expressed his appreciation for the award and noted special thanks to his wife, to Dr. Cook, and to his county medical society.

Dr. Kahn introduced the President, Dr. Louis C. Murray. Dr. Murray introduced his wife and their family, and then addressed the House.

The President's Address was referred to Reference Committee No. III.

The Speaker assumed the chair and announced the members of the Reference Committees, the assignment of AMA Delegates to the Reference Committees and the times that each Reference Committee would meet.

Reference Committee No. 1 — Health and Education
Thomas Bartley, M.D., Chairman
Karl Rolls, M.D.
David Hubbell, M.D.
Vincent P. Corso, M.D.
James T. Cook, M.D., AMA Delegate Advisor

Reference Committee No. II — Public Policy
Herbert E. Brooks, M.D., Chairman
Paul Tanner, M.D.
Clarence M. Gilbert, M.D.
Walter C. Jones, M.D.
Joseph Harris, M.D.
Richard G. Connar, M.D., AMA Delegate Advisor

Reference Committee No. III — Finance and Administration
Chauncey M. Stone, M.D., Chairman
Eugene Valentine, M.D.
Franklin Pfeiffenberger, M.D.
Brian P. Gibbons, M.D.
John H. Parker, M.D.
Samuel M. Day, M.D., AMA Delegate Advisor

Reference Committee No. IV — Legislation and Miscellaneou
Dick Van Eldik, M.D., Chairman
George N. Lewis, M.D.
H. Quillian Jones, M.D.
Joseph H. Davis, M.D.
Irving Essrig, M.D.
Joseph C. Von Thron, M.D., AMA Delegate Advisor

Reference Committee No. V — Medical Economics
Calvin W. Martin, M.D., Chairman
Charles P. Hayes, M.D.
George Messenger, M.D.
Maurice H. Laszlo, M.D.
James Schoeck, M.D.
Charles K. Donegan, M.D., AMA Delegate Advisor

Dr. Kahn announced that the assignment of Reports and Resolutions were as printed in the Handbook.

The Speaker then declared the House as a Reference Committee as a whole and requested a motion to approve the nomination of the Board of Governors of Wilson T. Sowder, M.D., to receive the Certificate of Merit, in order that the presentation could be made at the Second Meeting of the House before the Reference Committee Report was presented. The motion was made, seconded and carried unanimously to approve the nomination.

The Vice Speaker announced the assignment of Supplemental Reports and Resolutions which were received too late for inclusion in the Handbook, and which had been inserted into the Delegate's packets.

The Speaker called for additional reports or resolutions and reminded the House that unanimous consent is required for such presentation.

Samuel M. Day, M.D., Jacksonville, was granted the unanimous consent of the House and presented a resolution pertaining to Relative Value Studies. This Resolution was numbered 78-24 and referred to Reference Committee No. IV.

James L. Borland Jr., M.D., Jacksonville, was granted the unanimous consent of the House and presented a resolution concerning Health Insurance Claim Forms. This Resolution was numbered 78-25 and referred to Reference Committee No. V.

A special report on litigation involving the Association was presented by W. Harold Parham, D.H.A., Executive Vice President. This report was referred to Reference Committee No. III.

A Supplemental Report of the Public Relations Officer was presented by Vernon B. Astler, M.D. This report was referred to Reference Committee No. III.

A Report of the Florida Physicians' Insurance Reciprocal was presented by Vernon B. Astler, M.D. This report was referred to Reference Committee No. III.

The Speaker announced that William B. Deal, M.D., was the newly appointed Dean and Vice President of the Medical Affairs of the University of Florida College of Medicine.

It was announced that the Blue Shield Annual Meeting would be held at 8:00 a.m., Thursday, May 4, in the Regency Room North.

It was announced that the General Session would be held Friday, May 5, at 11:00 a.m., in the Regency Room North and would feature the President's Guest Speaker, Representative Philip M. Crane.

It was announced that a joint FLAMPAC-Auxiliary Luncheon would be held Friday, May 5, at 12:15 p.m., in the Cafe Cristal, with guest speaker Senator Richard S. Schweiker.

The House recessed at 6:00 p.m., to reconvene on Saturday, May 6, 1978, at 3:00 p.m.

General Session

The General Session of the 104th Annual Meeting of the Florida Medical Association was called to order at 11:00 a.m., on Friday, May 5, 1978, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, by the President, Louis C. Murray, M.D.

Dr. Murray introduced persons seated at the head table, then announced the winners of the scientific exhibit awards.

1978 Scientific Exhibit Awards

Honorable Mentions

Booth CC — "Pain and Suffering: A Neurosurgical Treatment" — Raul V. Rivet, M.D., Miami.

Booth M — "Technique and Indications for Axillo-Femoral and Bifemoral Bypass" — R. Vijayanagar, M.D., Paul F. Eckstein, M.D., and Diego A. Bognolo, M.D., Tampa.

Booth E-F — "Screening for Scoliosis in Florida Schools" — Joseph C. Flynn, M.D., William F. Enneking, M.D., Merlin G. Anderson, M.D., and Augusto Sarmiento, M.D., Florida Orthopedic Society.

Third Place

Booth HH — "Glaucoma Detection" — Florida Society for the Prevention of Blindness.

Second Place

Booth Q — "The Treatment of Myocardial Ischemia" — James R. Jude, M.D., R. Iyengar, M.D., and I. Boruchow, M.D., St. Francis Hospital, Miami.

First Place

Booth U-V W-X — "Harvey — Cardiac Patient Simulator" — Michael S. Gordon, M.D., Ph.D., University of Miami School of Medicine.

Mrs. Connie Moore, President of the FMA Auxiliary, presented checks representing funds raised for the Foundation by the Auxiliary in the amount of $10,200 earmarked for the disabled physician.

The President then called Dr. Gerold L. Schiebler, Journal Editor, to the platform to assist in presenting the awards for the First Annual JFMA Awards Contest for County Medical Society Bulletins.

Winners of First Annual JFMA Awards Contest for County Medical Society Bulletins

Best Editorial

Honorable Mention in this category goes to "Let Your Light So Shine" by Clyde M. Collins, M.D., in Jacksonville Medicine, December, 1977.
The Winner in this category is "Is Medicine Still a Profession?" by James K. Conn, M.D., in the Capital Medical Society Newsletter, March, 1977.



U.S. Rep. Philip M. Crane (R-Ill.) delivers the traditional Baldwin Lecture at the General Session on Friday.

Best Regular Feature

Honorable Mention in this category goes to Miami Medicine's Editorial Page (Dr. Edward St. Mary).
The Winner in this category is Dr. Guy T. Selander's President's Pages, 1977, in Jacksonville Medicine.

Special Recognition

Honorable Mention in this category is for Photography and Color in the Imperial Polk County Medical Association Bulletin, September, 1977, and the Woman's Auxiliary Page from the Imperial Polk County Medical Association Bulletin, 1977.
The Winner in this category is Hillsborough County Medical Association Bulletin for their series on "Transplantation."

Most Improved Bulletin

The Winner of this category is the Bulletin of the Palm Beach County Medical Society.

General Excellence

The Winner of this category is Hillsborough County Medical Association Bulletin.

Dr. Murray then called Dr. Sanford Mullen to give a special report on the 125th Anniversary of the founding of the Duval County Medical Society by Abel S. Baldwin, M.D., who also founded the Florida Medical Association.

Dr. Murray introduced Representative Philip M. Crane who presented the annual Baldwin Lecture.

Physicians must stand firm in their opposition to governmental intervention in medicine, or socialized health care will become a reality in the United States, warned Representative Philip M. Crane. The Illinois Congressman delivered the Abel S. Baldwin Lecture during the General Session, and urged physicians to actively oppose attempts by government to gain a foothold in the medical community.



Winners in the First Annual Journal of the Florida Medical Association Awards Contest for County Medical Society Bulletins were announced by President Louis C. Murray, M.D., during the General Session on Friday. Receiving awards are: (upper left) Edward Pedrero, M.D., Editor of The Hillsborough County Medical Association Bulletin, which won top honors for general excellence and in special recognition for a series on transplantation; (upper right) Guy Selander, M.D., Past President of the Duval County Medical Society, for his series of President's Pages which were considered the best regular feature in the competition; (lower left) Dick L. Van Eldik, M.D., Editor of The Bulletin of the Palm Beach County Medical Society, adjudged the most improved county bulletin; and (lower right) James K. Conn, M.D., Editor of the Capital Medical Society Newsletter. Dr. Conn's "Is Medicine Still a Profession?" was voted the best editorial in the competition.

"Your enemy first of all is government and don't be fooled by any of their ingratiating overtures because they are out to get control — they don't care about quality, they don't care about costs — it is control first and foremost," he stated.

Private practice and the medical profession are being battered by statistics cranked out by proponents of a national health network determined to defame the current system, Crane explained. The arguments, however, are fallacious, employing figures that are in error, statistics taken out of context and data gained without regard to variables.

Crane reviewed some of the popular arguments favoring a national health system, such as the maldistribution of physicians, doctor-patient ratios, physicians' fees, hospital costs and infant mortality rates. Infant mortality rates in the United States cannot be compared with rates quoted by nations which use different criteria to determine infant mortality, he said, because the only comparable figures exist in Common Market nations, all of which have opted for some degree of government medicine. When viewed in this context, the United States must be rated superior.

In addressing the topic of maldistribution of physicians, Crane cited the argument that 132 of America's 3,084 counties are without physicians. This superficial statement was then negated by the facts that 36 of these doctorless counties are within a few minutes drive of major metropolitan areas such as Washington, D.C.; that 32 of the "doctorless" counties support two or more doctors of osteopathy; and that these 132 counties represent only two tenths of one percent of the national population.

Don't accept a national health system as an inevitability, Crane urged, because that is the first step toward compromise, and compromise is a step in the wrong direction. He advised physicians not to accept any third party payments to avoid being "drawn into" the system, and he predicted that PSRO's will "lead to cookbook medicine."

The only hedge against a national health system is through education, he noted, and suggested that physicians arm themselves with facts and begin fighting.

Dr. Murray adjourned the meeting at 12:15 p.m.

Second House of Delegates

The Second Meeting of the House of Delegates convened at 3:00 p.m., Saturday, May 6, 1978, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with Dr. Charles J. Kahn, Speaker of the House, presiding.

Dr. John Glotfelty, Chairman of the Credentials Committee, reported that 230 delegates were present with 39 component societies represented, constituting a quorum, and moved the delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; William B. Deal, M.D.; James C. Garlington, M.D.; Douglas O. Jenkins, M.D.; William W. Pfaff, M.D.; Gerold Schiebler, M.D.; James Campbell, Student Delegate.

BAY — Phillip Cotton, M.D.: James D. Nixon, M.D.

BREVARD — Richard N. Baney, M.D.; Edwin E. Hadden, M.D.; Laudie E. McHenry, M.D.; Burton Podnos, M.D.; Michael J. Foley, M.D.; Howard W. Pettengill, M.D.

BROWARD — Charles H. Bechert II, M.D.; Robert J. Brennan, M.D.; Bruce B. Burgess, M.D.; Andre S. Capi, M.D.; Burns A. Dobbins, M.D.; Arthur L. Eberly, M.D.; Theodore W. Hahn, M.D.; Norbert Skaja, M.D.; David C. Lane, M.D.; George P. Messenger, M.D.; James B. Perry, M.D.; Thomas F. Regan, M.D.; Joseph M. Sachs, M.D.; Ernest G. Sayfie, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; Juan S. A. Wester, M.D.; (Absent — Robert L. Andreae, M.D.; Charles M. Bonura, M.D.; Russell B. Carson, M.D.; Phillip A. Caruso, M.D.; Milton P. Caster, M.D.; Willis N. Dickens, M.D.; Richard S. Doyle, M.D.; F. Gary Gieseke, M.D.; William C. Hartley, M.D.; Floyd A. Osterman, M.D.; Raymond E. Parks, M.D.; Diran M. Seropian, M.D.)

CAPITAL — Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; Jack W. MacDonald, M.D.; Robert N. Webster, M.D.; (Absent — George N. Lewis, M.D.)

CHARLOTTE — Melvyn J. Katzen, M.D.; (Absent — Thomas R. Civitella, M.D.)

CITRUS-HERNANDO — James J. Cuffe, M.D.; W. Randall Jenkins, M.D.

CLAY — Laurin G. Smith, M.D.

COLLIER — Virgil A. Ponzoli Jr., M.D.; Donald Q. Vining, M.D.; Robert J. Wald, M.D.

COLUMBIA — Henry E. Plenge, M.D.

DADE — Seymour Alterman, M.D.; Edward Annis, M.D.; Robert L. Beshany, M.D.; Rufus K. Broadaway, M.D.; Luis A. Cabrera, M.D.; Manuel L. Carbonell, M.D.; Sol Center, M.D.; Richard C. Clay, M.D.; Jack Q. Cleveland, M.D.; Vincent P. Corso, M.D.; Victor Dabby, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Diane B. Eisman, M.D.; Franklin J. Evans, M.D.; Miguel Figueroa, M.D.; Richard M. Fleming, M.D.; George R. Gage, M.D.; Stephen H. Glucroft, M.D.; L. Marshall Goldstein, M.D.; Max E. Gomez, M.D.; Norman Gottlieb, M.D.; Alan S. Graubert, M.D.; Maurice Greenfield, M.D.; Julian H. Groff, M.D.; Leo Grossman, M.D.; Marshall Hall, M.D.; Joseph Harris, M.D.; Walter C. Jones III, M.D.; James R. Jude, M.D.; Norman M. Kenyon, M.D.; Banning G. Lary, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Charles Monnin, M.D.; Joseph T. Ostroski, M.D.; Milton S. Ross, M.D.; Walter M. Sackett, M.D.; Oscar Sandoval, M.D.; Everett Shocket, M.D.; Samuel P. Stokley, M.D.; Chauncey M. Stone, M.D.; William M. Straight, M.D.; John Turner, M.D.; Charles F. Tate, M.D.; Edgar W. Webb, M.D.; Elliot Witkind, M.D.; Sheldon Zane, M.D.; Shreve Archer, Student Delegate; (Absent — Jose S. Bocles, M.D.; Leo Braverman, M.D.; John E. Cunio, M.D.: Eduardo E. Delgado, M.D.; Robert W. Elkins, M.D.; Ivor Fix, M.D.; Eugene Flipse, M.D.; Richard L. Glatzer, M.D.; Pedro J. Greer, M.D.; Henry C. Hardin, M.D.; Marvin Jaffee, M.D.; Robert B. Katims, M.D.; Martin E. Liebling, M.D.; Carlos G. Llanes, M.D.; Ildefonso R. Mas, M.D.; Raul Rivet, M.D.; Edward St. Mary, M.D.)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Warren M. Barrett, M.D., William P. Booras, M.D.; Doris N. Carson, M.D.; Yank D. Coble, M.D.; Patricia Cowdery, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Emmet F. Ferguson Jr., M.D.; Clifford R. Guy, M.D.; Charles P. Hayes Jr., M.D.; John C. Kruse, M.D.; Charles B. McIntosh, M.D.; Charles W. Lewis, M.D.; Daniel Nunn, M.D.; B. Craig Ray Jr., M.D.; John A. Rush, M.D.; Guy T. Selander, M.D.; William D. Walklett, M.D.

ESCAMBIA — George L. Carr, M.D.; Eric F. Geiger, M.D.; Kenneth I. Holman, M.D.; Charles F. McConnell, M.D.; Henry M. Yonge, M.D.; (Absent — Robert K. Wilson, M.D.)

FRANKLIN-GULF — Joseph P. Hendrix, M.D.

HIGHLANDS — (Absent — Glenn V. Hough, M.D.; Robert T. Rengarts, M.D.)

HILLSBOROUGH — Richard A. Bagby, M.D.; Louis E. Cimino, M.D.; Francis C. Coleman, M.D.; Irving M. Essrig, M.D.; Richard S. Hodes, M.D.; Donald W. Irvine, M.D.; Victor H. Knight Jr., M.D.; Joel W. Mattison, M.D.; Thomas E. McKell, M.D.; John K. Petrakis, M.D.; Ronald L. Seeley, M.D.; Ralph M. Stephan, M.D.; William W. Trice, M.D.; Harold L. Williamson, M.D.; Woody N. York, M.D.; Henry P. Freider, Student Delegate; (Absent — Robert J. Courtney, M.D.; John C. Fletcher, M.D.)

INDIAN RIVER — Donald L. Ames, M.D.; Ferdinand F. Becker, M.D.

LAKE — Frederick C. Andrews, M.D.; James M. Hardy, M.D.; Thomas D. Weaver, M.D.

LEE — Larry P. Garrett, M.D.; John S. Hagen, M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr., M.D.; Marcus M. Moore, M.D.

MADISON — (Absent — William J. Bibb, M.D.)

MANATEE — Thomas R. Busard, M.D.; Sanford Elton, M.D.; John D. Lehman, M.D.; Roger A. Meyer, M.D.

MARION — C. Brooks Henderson, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; Richard Q. Penick, M.D.

MONROE — Ronald H. Chase, M.D.; (Absent — Robert P. Kaminsky, M.D,)

NASSAU — Jose L. Castillo, M.D.

OKALOOSA — David R. Arrowsmith, M.D.; Eugene R. Valentine, M.D.

ORANGE — Clarence H. Brown III, M.D.; Stephan A. Butler, M.D.; Manuel J. Coto, M.D.; Sam F. Elder, M.D.; Clarence M. Gilbert, M.D.; Dorothy T. Lloyd, M.D.; David L. Mackey, M.D.; Franklin B. McKechnie, M.D.; Robert A. Metzger, M.D.; James F. Richards Jr., M.D.; James J. Schoeck, M.D.; Edward W. Stoner, M.D.; T. Byron Thames, M.D.; Robert B. Trumbo, M.D.; (Absent — Donald V. Jablonski, M.D.; Hector Mendez, M.D.)



Two former Florida governors and the emissary of a third turned up at the Annual Meeting to help the FMA honor former State Health Officer Wilson T. Sowder, M.D. (right). Dr. Sowder, who retired a few years ago after a 29-year tenure as Health Officer, received the Certificate of Merit, the Association's Highest Award. Participating in the presentation ceremony were Claude Kirk Sr., father of the immediate past Governor (lower left); former Gov. Haydon Burns (lower center); and former Gov. LeRoy Collins.







OSCEOLA — George A. Gant, M.D.
PALM BEACH — Vernon B. Astler, M.D.; John D. Corbitt Jr., M.D.; Lee Fischer, M.D.; James R. Forlaw, M.D.; Luis R. Guerrero, M.D.; V. A. Marks, M.D.; Charles E. Metzger, M.D.; Benjamin Moore, M.D.; Roger D. Petersen, M.D.; Reginald J. Stambaugh, M.D.; Arthur L. Trask, M.D.; Dick L. Van Eldik, M.D.; (Absent — Thomas E. Murphy, M.D.; Harold A. Yount, M.D.)
PANHANDLE — Herbert E. Brooks, M.D.; William F. Brunner, M.D.
PASCO — Nessan McCann, M.D.; Morris L. Saperstein, M.D.
PINELLAS — Thomas M. Daniel, M.D.; Charles K. Donegan, M.D.; Kay K. Hanley, M.D.; David S. Hubbell, M.D.; Morris J. LeVine, M.D.; Donald I. MacDonald, M.D.; Jack A. MaCris, M.D.; William F. Mallette, M.D.; Frank I. Mendelblatt, M.D.; James Hugh Miller, M.D.; James M. Neill, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Robert N. Price, M.D.; Frederick O. Smith, M.D.; (Absent — Robert L. Dawson, M.D.)
POLK — Salvadore J. Barranco, M.D.; Thomas M. Caswall, M.D.; Frank J. Fischer, M.D.; John W. Glotfelty, M.D.; Wiley E. Koon, M.D.; Stanley W. Lipinski, M.D.; Paul A. Tanner Jr., M.D.; (Absent — Clyde E. Gibson, M.D.)
PUTMAN — Craig Raby, M.D.
ST. JOHNS — Constantine Antonatos, M.D.; Reuben J. Plant, M.D.
ST. LUCIE-OKEECHOBEE — William H. Meyer Jr., M.D.; Bruce E. Mills, M.D.
SANTA ROSA — (Absent — William N. Watson, M.D.)
SARASOTA — Wallace M. Bryant, M.D.; John N. Carlson, M.D.; Samuel E. Kaplan, M.D.; Kenneth C. Keihl, M.D.; Franklin Pfeiffenberger, M.D.; Richard E. Rehmeyer, M.D.; Karl R. Rolls, M.D.
SEMINOLE — Luis M. Perez, M.D.; Frederick J. Weigand, M.D.
SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Laurent V. Radkins, M.D.)
TAYLOR — John H. Parker, M.D.
VOLUSIA — Richard L. Dillard, M.D.; Irwin Leider, M.D.; Frank J. Lill, M.D.; Alvin E. Smith, M.D.; James G. White, M.D.; (Absent — Charles A. Stump, M.D.)
WALTON — (Absent — Thomas G. Spence, M.D.)
SPEAKER OF THE HOUSE — Charles J. Kahn, M.D.
VICE SPEAKER — Sanford A. Mullen, M.D.

The President introduced the following former Governors of Florida who were present for the presentation of the Certificate of Merit to Wilson T. Sowder, M.D., who had served as State Health Officer under 11 Governors: The Honorable Haydon Burns; The Honorable Leroy Collins; and, representing The Honorable Claude Kirk Jr., Claude Kirk Sr. Each of the Former Governors and Mr. Kirk spoke briefly of his relationship with Dr. Sowder as State Health Officer during their respective terms as Governor. Each praised Dr. Sowder and commended his efforts in that position.

Dr. Murray requested Dr. Sowder to come forward to receive the Certificate of Merit. Dr. Sowder accepted the Certificate and expressed his pleasure and gratitude for this honor.

Certificate of Merit

Wilson Thomas Sowder, M.D.

Whereas, Wilson Thomas Sowder, M.D., of Jacksonville, Florida, has rendered distinguished and able service to the medical profession and the citizenry of Florida since 1945; and

Whereas, This dedicated physician was born in Callaway, Virginia, on February 27, 1910; attended the University of Virginia, and was graduated with an M.D. degree; and

Whereas, This eminent gentleman was associated with the University of Iowa Hospitals; St. Lukes Hospital, San Francisco, California; and was Assistant Surgeon with the United States Public Health Service; and

Whereas, This conscientious physician attended Johns Hopkins University School of Public Health and was graduated with a Master of Public Health Degree; and

Whereas, Dr. Sowder served as Florida State Health Officer for 29 years, during which time great advances were made in medical care in the state and many health hazards were eliminated or reduced; and

Whereas, Dr. Sowder actively supported and encouraged the establishment of county health departments in Florida, increasing the number until each county had a full-time health department; and

Whereas, Under Dr. Sowder's leadership programs of air and water pollution control were instituted, as well as programs of radiation surveillance, mosquito control, chronic diseases, hospitalization for the indigent; mental health programs were developed; the importance of research and laboratory facilities was realized; and

Whereas, Many physicians and dentists in practice today are indebted to Dr. Sowder's dedication to the idea of medical and dental scholarship programs; and

Whereas, This able physician served as consultant to the United States Foreign Operations Administration in Columbia, Panama and Ecuador; as Advisor to the United States Delegation to the 13th World Health Assembly in 1960; and as consultant to the Government of Ecuador in the establishment of a Ministry of Health under the auspices of the U.S. Department of State; and

Whereas, Dr. Sowder served at the request of the United States Surgeon General in organizing the Office of the Aging in the U.S. Public Health Service; and

Whereas, Dr. Sowder has served as President of the American Association of Public Health Physicians, the Association of State and Territorial Health Officers, and the Florida Public Health Association; and

Whereas, This distinguished physician has served as Chairman of the Executive Board of the American Public Health Association and as an Associate Editor of the *Journal of the Florida Medical Association*, and

Whereas, Dr. Sowder served as a visiting professor of Preventive Medicine to the University of Miami School of Medicine and the University of Florida College of Medicine; and

Whereas, Dr. Sowder is currently compiling the history of his years in the Florida Public Health Service under 11 Governors; and

Whereas, Dr. Sowder has given freely of his time and talent to the medical community and the people of the State of Florida; therefore be it

RESOLVED, That a Certificate of Merit be presented to Wilson Thomas Sowder, M.D., as a token of the warm regard and respect that the officers, members and executive staff of the Florida Medical Association hold for the many years of outstanding service rendered by this fine gentleman.

Dr. Murray invited Mr. Charles Dallas Reach to come to the podium to receive the Distinguished Layman Award.

Distinguished Layman Award

Charles Dallas Reach

Whereas, Charles Dallas Reach of Naples, Florida, is the founder of the innovative public health information program called Prevent-A-Care, which was conceived as a means of preventing and detecting cancer and heart disease; and

Whereas, This program was instituted in the Collier County school system in 1973, and has since grown to include a public health fair which reaches thousands of people annually; and

Whereas, Prevent-A-Care has been successful in reaching the public and informing them about preventive medicine; and

Whereas, This program has helped thousands of people become more aware of their health and the value of life; and

Whereas, Charles Dallas Reach has given unselfishly of his time and talents to make the Prevent-A-Care program an example of what can be done in the field of preventive medicine; and



Mr. Charles Dallas Reach of Naples receives the Distinguished Layman Award from President Louis C. Murray, M.D. Mr. Reach was cited for being the founder of Prevent-A-Care, a Collier County program for the prevention and detection of cancer and heart disease.

Whereas, The Prevent-A-Care concept has been used as an example by communities throughout the United States, and has been commended by numerous organizations; and

Whereas, He has found time to serve on the President's Council on Aging, as well as working on various community projects; and

Whereas, Charles Dallas Reach is currently working to combine the talents of private physicians and modern technology into a diagnostic clinic which will bear out his philosophy that the private sector can compete with government programs; and

Whereas, He is a firm believer in the theory that illness can be prevented and not just treated; and

Whereas, Charles Dallas Reach continues to serve his community, the State of Florida, and the nation with his talent, energy and time, therefore be it

RESOLVED, That upon the unanimous vote of the Board of Governors, the Florida Medical Association at its 104th Annual Meeting at Hollywood, Florida, May 3-7, 1978, present to Charles Dallas Reach its Distinguished Layman Award.

Mr. Reach expressed his appreciation for the award and his thanks to the many physicians who have given guidance and counsel to him in his Prevent-A-Care Program.

The President presented grants from the AMA-ERF to Medical School Deans in the following amounts:

William B. Deal, M.D., Dean, University of Florida College of Medicine, $6,159.39; Hollis G. Boren, M.D., Dean, University of South Florida College of Medicine, $4,013.50; Emanuel M. Papper, M.D., Dean, University of Miami School of Medicine, $3,868.73; Paul R. Elliott, Ph.D., Director, Florida State University Program in Medical Science, accepted by Dr. Deal.

Mrs. R. Benjamin Moore, Auxiliary Past President, presented each medical school dean with a check in the amount of $9,875, representing contributions from the Florida Medical Association Auxiliary AMA-ERF Program.

Dr. Murray presented the First Annual FMA Awards for Excellence in Medical Journalism to the following:

In the category of Newspapers, circulation over 35,000, *Pensacola News-Journal* for its nine-week Sunday Series titled "Operation Good Health."

In the category of Radio, Paul Henderson, WIOD Radio, Miami, for four five-minute programs on C.P.R.; Implantation of a "Brain Pacemaker;" and Burn Facilities in South Florida (two articles).

In the category of television, WPTV Television, West Palm Beach, for its program, "Call the Doctor."

Special recognition was given Fort Myers News-Press, for its series of articles on various medical subjects.

Dr. Kahn requested and received the unanimous consent of the House to deviate from the general order of business by taking the reports of the reference committees in reverse order to expedite the proceedings of the House.

The First Annual FMA Awards for Excellence in Medical Journalism were presented during the Annual Meeting. In left picture below, Mr. Buddy Baker, Managing Editor of the Pensacola News-Journal, acknowledges an award made to his newspaper for a nine week series entitled "Operation Good Health." In center photo, Mr. Paul Henderson of Miami radio station WIOD displays a certificate awarded to his station for a series of five-minute programs on health matters. At right, Mr. Robert Regalbutto, general manager of Palm Beach television station WPTV, holds a certificate awarded a program entitled "Call the Doctor," which has been aired over his station for 16 years. A certificate also was awarded to the Fort Myers News-Press for its medical reporting.







Report of Reference Committee No. V Medical Economics

Dr. Calvin Martin, Chairman, and his committee came forward to present the report of Reference Committee No. V, Medical Economics.

Council on Medical Economics

"The Reference Committee considered the report of the Council on Medical Economics. The Committee was enthusiastic in its praise of Dr. James F. Richards, Chairman, Council on Medical Economics, and its component committees. Under the Council's activities relating to the Workmen's Compensation portion of the report, it was noted that the four digit code has been replaced by the five digit code system used in the 1975 Florida Relative Value Studies and that Usual and Customary Charges are to be entered on the Workmen's Compensation Form."

The motion of the Reference Committee that the Board of Governors of the FMA be requested to establish a date by which time the Workmen's Compensation Bureau should have accumulated sufficient data concerning workmen's compensation fees to enable them to comply with the law and compensate at the usual and customary fee; that this date be reported to the House of Delegates next year; and that if the usual and customary compensation is not implemented by the date established by the Board, appropriate action should be taken, carried.

The motion of the Reference Committee that the report of the Council on Medical Economics be adopted as printed in the handbook carried.

Council on Medical Economics

James F. Richards Jr., M.D., Chairman

There was no formal meeting of the Council on Medical Economics during 1977-78, although communications were maintained by phone and letter between the Chairman of the Council and the Chairmen of the committees.

Committee on Relative Value Studies — Questions on Relative Value Studies have been effectively answered by the 1975 Florida RVS edition, and subsequent actions of the Committee on Relative Value Studies. Joel Mattison, M.D., Chairman, and his committee have handled questions and complaints effectively, and it was necessary to have only one meeting of the full committee which was held January 21, 1978. There was disposition made of problems arising from duplicate codes and descriptors, making the 1975 Florida RVS consistent with CPT-4.

Committee on Health Insurance — No major problems arose during the year. Most questions that do arise within the Health Insurance industry can be and are handled by staff. It was not necessary for the committee, chaired by Phil Cotton, M.D., to meet this year.

Workmen's Compensation — The Chairman of the Council continued to work through his position on the Statutory Advisory Council to Workmen's Compensation to effect improvements in the Medical and Surgical W/C Fee Schedule. The W/C Advisory Council



Reports and resolutions relating to medical economics were considered by Reference Committee V. Left to right: Charles K. Donegan, M.D., St. Petersburg, AMA Delegate Advisor; James Schoeck, M.D., Orlando; Charles P. Hayes, M.D., Jacksonville; George P. Messenger, M.D., Fort Lauderdale; Maurice H. Laszlo, M.D., North Miami Beach; Ms. Marcia Protheroe, Jacksonville, Recording Secretary; and Calvin W. Martin, M.D., Arcadia, Chairman.

became convinced that there should be at least several levels of compensation for Office Visit and Hospital Visit. At the request of the Bureau of Workmen's Compensation, the Chairman of the Medical Economics Council, with help from Blue Shield, completely converted the Workmen's Compensation Fee Schedule, a four digit code, to the appropriate five digit code as in the 1975 Florida RVS.

It is planned that sometime in the Spring of 1978, the Workmen's Compensation Bureau will begin to use and recognize, at least for awhile, both the four and five digit codes and eventually convert to the latter, the system used in the 1975 RVS.

It is also intended that sometime in the Spring a new reporting form will be disseminated to the doctors of Florida in which they can list both the W/C Fee Schedule fee and their Usual and Customary fee beside it. It will be appropriate when the time comes for FMA to send additional information on this new form to the physicians of Florida.

Special Committee on the Cost of Medical Care — Although the Cost of Medical Care Committee has not been under the Council on Medical Economics, its activities, for the past several years, have been reported herein. The committee was active as a special committee of the board, chaired by James F. Richards Jr., M.D. The committee dissolved in January 1978, simultaneous with the formation of a broader based committee, encompassing other organization representation, such as Florida Hospital Association, Blue Cross/Blue Shield, Health Insurance Council and Industry. Louis C. Murray, M.D., FMA President, appointed J. Lee Dockery, M.D., and James F. Richards Jr., M.D., to represent FMA on the new committee.

The Chairman would like to thank Joel Mattison, M.D., and Phil Cotton, M.D., for the time and energy contributed to FMA as Chairmen of their respective committees over the past year. We also thank the FMA staff for its considerable help and kindness.

Council on Medical Systems

The report of the Council on Medical Systems was reviewed. Dr. James L. Borland, Jr., was commended by the Committee as Chairman of this Council, and the work done by the component committees was recognized.

The motion of the Reference Committee that the report of the Council on Medical Systems be adopted as printed in the handbook carried.

Council on Medical Systems

James L. Borland Jr., M.D., Chairman

The Council on Medical Systems had a moderately active year. The Council considered such varied items as the proposed contracts for Peer Review for the Medicaid Program, monitored the H.S.A. activities as well as the activities of the P.S.R.O. development, and was involved with the consideration for moving into Peer Review of large industrial companies and their insurance contracts. In addition, the Council was involved in the finalization of the Florida Health Data Corporation which had been its charge for the previous year. The Council held meetings September 27, 1977 and January 11, 1978.

Committee on Peer Medical Utilization Review. It proved to be a very active year for the Committee on Peer Medical Utilization Review, chaired by Frank B. Hodnette, M.D. The Committee met on May 2-3, 1977, August 26-27, 1977, January 26-29, 1978, and its next meeting is scheduled for April 1978. The Committee conducted 81 initial reviews and 18 peer review appeals. In addition, the Committee conducted 22 health insurance appeals for various health insurance carriers throughout the state. In fact, due to the increased case load and the advent of peer review for the Medicaid program, the Committee anticipates the necessity of appointment of additional members to the Committee.

At its January meeting, the Committee conducted its first peer reviews for Group Health, Incorporated, the fiscal intermediary for the Medicare program in Dade and Monroe counties. After a brief presentation by the staff of GHI, the Committee found that the format used by GHI is very similar to that which is used by Blue Shield of Florida. The Committee foresees no major problems in conducting these reviews and appreciates the cooperation extended to it in this new endeavor.

One of the primary objectives accomplished by the Committee was the development of a procedures manual for peer review. This manual, after final editing and approval, will be distributed to each county medical society. It is designed not only to assist the physician members of the local committee with utilization determinations, but also to assist the county medical staff responsible for administering the peer review program at the local level. It is hoped that the manual will be ready for distribution by May 1978.

The Committee on PMUR has been closely following the progress of the Medicaid peer review program. Since the signing of a contract by the Florida Medical Foundation and the Department of Health and Rehabilitative Services on October 31, 1977, several meetings have taken place regarding an operating procedures manual. The final version of this manual, which closely parallels the manual for the Medicare program, has now been adopted. However, the Department of HRS is not yet in a position to forward any claims to the Committee for review.

In the past two years, there has been a great increase in the number of health insurance claims submitted to the Florida Medical Association for review. In order to process these claims more efficiently, the Committee found it necessary to revise the operating procedures for health insurance review. Among other revisions, the procedures now require written documentation that the physician involved in the dispute has first been contacted by the insurance carrier before submission of the claim to the Florida Medical Association. The Committee feels this revision will alleviate many of the problems inherent in these disputes. Also, due to the rising cost of conducting such reviews, it was deemed necessary to raise the administrative fee to $50 per case.

In summary, the Committee feels it was a very constructive year and asks for continued support for its many endeavors.

Committee on Foundations, PRO & Medicaid. On October 5, 1977, the Florida Medical Association was contacted by the Department of Health and Rehabilitative Services and asked to participate in a project designed to explore and recommend substantive remedial action for Florida's Medicaid Program. In addition to the FMA, the following organizations were asked to also participate: Florida Hospital Association, Florida Health Care Association, Florida Pharmaceutical Association, Florida Dental Association, State Association of County Commissioners, Florida Legal Services and the Association of County Welfare Executives. FMA's participation in this project was turned over to the FMA Committee on Foundations, PRO & Medicaid, chaired by H. Phillip Hampton, M.D.

To date, there has been participation in two formal meetings involving the "Medical Services Redevelopment Project" and numerous informal meetings with various Redevelopment Project staff. The formal meetings have resulted in the drafting of two "concept papers;" each "concept paper" was a synthesis of the input made by all the organizations involved and did not reflect any specific policy of any individual participating organization. Currently, DHRS is developing some draft legislation designed to reorganize the Medicaid Program from a staff and delivery point of view, as well as a federal/state funding program designed to increase the amount of available funds to better

support the program.

The Committee on Foundations, PRO & Medicaid is not only participating in the "Medical Services Redevelopment Project," but is currently reviewing the proposed Medicaid budget for fiscal year 1978-79, in hopes of developing a presentation that will encourage funding realistically in accord with acknowledged objectives oriented toward ambulatory care as opposed to inappropriate utilization of institutional care.

In accordance with a request by Congressman Paul Rogers for the FMA to study the feasibility of using the insurance mechanism to implement Medicaid which was forwarded to the Committee, proposals are being developed for pilot programs.

A statement on Health Care for the Indigent was prepared by the Committee, considered by the Council and forwarded to the FMA Board of Governors.

Committee on Hospitals and Extended Care Facilities. Although no formal meeting was held by the Committee on Hospitals and Extended Care Facilities, chaired by Jerry F. Cox, M.D., communications were maintained. At the present time the Committee is studying the problems involving home health care agencies in Florida and ways for improving and strengthening this method of health care delivery.

Committee on Government Programs. The Committee on Government Programs, chaired by Edward L. Farrar Jr., M.D., is continuing liaison with the FMA Capital Office to study and evaluate various government programs.

The Council on Medical Systems would like to thank Mr. John Richardson, Mr. Philip Gilbert and our new council staff executive, Mr. Jean Burner, for their invaluable assistance during the year.

Supplemental Report
Florida Health Data Corporation, Inc.

The Reference Committee read the Supplemental Report of the Florida Health Data Corporation with much interest. The Committee was unanimous in its admiration for Dr. Borland, President, Florida Health Data Corporation, and the other representatives of this Corporation, for their fine work.

The motion of the Reference Committee that the supplemental report of the Florida Health Data Corporation be adopted as printed in the handbook carried.

Supplemental Report

Florida Health Data Corporation, Inc.

James L. Borland Jr., M.D.

The Florida Health Data Corporation, Inc., formed by the Florida Hospital Association, the Florida Medical Association and the Florida Osteopathic Medical Association in 1977, spent a very busy year and anticipates much activity in the coming months.

A contract was completed on January 16, 1978, with Medical Dimensions, Inc. of Houston, Texas to begin a pilot program involving twelve Florida hospitals in the FHDC's Hospital Management and Medical Information System (HMMIS). At the end of the pilot program, the FHDC system will be offered to all Florida hospitals that wish to participate. The contract with Medical Dimensions is carefully worded to ensure maximum confidentiality of the data. Start-up funds were provided by the component member organizations of the FHDC for the pilot program and the FHDC Board of Directors has been furnished liability coverage.

It is the intent of the Florida Health Data Corporation to provide a quality system which will not only provide the basic management information needed by hospitals but will also assist Florida hospitals in dealing with the data demands of quality review and health planning.

Mrs. Jeanne H. Tucker, RRA, well known in Florida hospital medical records circles, and past president of AMRA, has worked with the FHDC developing its system and is supervising the pilot program.

The Florida Health Data Corporation will continue, through its Board of Directors, to monitor its data system and looks forward to a successful and productive future.

Board of Governors Report

Referrals By 1977 House of Delegates

Resolution 77-5

Health Systems Agencies

The motion of the Reference Committee that the Board's Report concerning Resolution 77-5 and Recommendation No. 2 be adopted as printed in the handbook carried. (See Board Report, page 530.)

Resolution 77-16
Waiver of Coverage

The motion of the Reference Committee that the Board's Report concerning Resolution 77-16 be adopted as printed in the handbook carried. (See Board Report, page 531.)

Resolution 77-25
Medicare Physicians' Profiles
and
Supplemental Report Board of Governors Re: Blue Shield of Fla., Inc. — Medicare and Resolution 77-25

Since Resolution 77-25, Medicare Physicians' Profiles, and the Supplemental Report of the Board of Governors concerning Blue Shield of Florida, Inc. - Medicare and Resolution 77-25, pertain to the same subject, they were considered together by the Reference Committee.

It was the consensus of the Reference Committee that it was in the best interest of the physicians of Florida and their patients that the FMA continue its sponsorship and endorsement of Blue Shield of Florida, Inc.

The Reference Committee recommended that the House of Delegates also support Blue Shield in its role as fiscal intermediary for Medicare, Part B, as this affords the FMA continuing input and access to valuable information.

Based on the testimony received and careful consideration by the Reference Committee, the



U.S. Sen. Richard S. Schweiker (R-Pa.) was the principal speaker at the Annual Auxiliary-FLAMPAC Luncheon on Friday.

following reasons for the observations made were:

1) Blue Shield's performance as a carrier was superior to GHI in the Dade-Monroe area; 2) FMA and its membership has access to more information, earlier, from Blue Shield as a carrier, than from the other insurance companies; 3) There are more opportunities for influence of final regulations through Blue Shield than other potential carriers; 4) The financial status of Blue Shield could be jeopardized, thus severely and adversely affecting the premiums to the private subscriber; 5) The dissemination of information which the FMA considers confidential and the implementation of dual fee schedules would not be altered by changing to another carrier; 6) Blue Shield is not the instigator of adverse policies established by Medicare.

The motion of the Reference Committee that the Board's Report in the handbook on Resolution 77-25 be filed carried. (See Board Report, page 531.)

The Reference Committee moved that the Board's Supplemental Report distributed at the First House dealing with Resolution 77-25 not be adopted.

A substitute motion to refer the Supplemental Report of the Board of Governors back to the Board for further review failed to carry.

A substitute motion for Blue Shield to continue to serve as the fiscal intermediary for Medicare, Part B, but to refuse to release the names of physicians and their profiles or fees failed to carry.

A substitute motion was made to refer the Supplemental Report of the Board of Governors concerning Blue Shield-Medicare-Resolution 77-25, to a committee composed of representatives of Blue Shield of Florida Board of Directors and representatives of FMA Board of Governors; that the Committee investigate and report to the House of Delegates of FMA the existing contracts between Blue Shield of Florida and the federal government; that the Committee determine and report the implications of Blue Shield withdrawing from all federal contracts; and finally that the Committee determine and report the implications of FMA withdrawing sponsorship of Blue Shield of Florida.

An amendment was moved but there was no second. The substitute motion carried. (See page 546.)

A motion that the House of Delegates reaffirms support of the FMA Board of Governors in their lawsuit against HEW, and that the Board does represent the physicians of Florida, carried.

Board Actions of Major Importance

Health Planning Activities

The motion of the Reference Committee that the Board's Report concerning health planning activities be adopted as printed in the handbook carried. (See Board Report, page 532.)

Health Data System

The motion of the Reference Committee that the Board's Report concerning health data system be adopted as printed in the handbook carried. (See Board Report, page 532.)

Medicaid

The motion of the Reference Committee that the Board Report concerning Medicaid be adopted as printed in the handbook carried. (See Board Report, page 532.)

FMA Councils and Committees Section

Florida Committee on the Cost of Medical Care

The motion of the Reference Committee that the Board's Report concerning the Florida Committee on the Cost of Medical Care by adopted as printed in the handbook carried. (See Board Report, page 541.)

Committee on HSA's

A motion that the Board's Report concerning the Committee on HSA's be deferred so that it might be considered with Resolution 78-19, Staff Personnel for H.S.A. monitoring, which was referred to Reference Committee No. III, carried. (See page 541 for discussion.)

Council on Medical Economics

The motion of the Reference Committee that the Board's Report concerning the Council on Medical Economics be adopted as printed in the handbook carried. (See Board Report, page 543.)

Council on Medical Systems

The Reference Committee in reviewing the Board of Governor's Report on the Council on Medical Systems, recognized the time and energy spent by Dr. Frank Hodnette, and his Committee on PMUR, in revising the Operating Procedures for Health Insurance Review, and commended Dr. Hodnette and the Committee on PMUR.

The motion of the Reference Committee that the Board's Report on the Council on Medical Systems, including Recommendation Nos. 22, 23, and 24, be adopted as printed in the handbook carried. (See Board Report, page 543.)

Blue Shield of Florida

The motion of the Reference Committee that the Board Report regarding Blue Shield of Florida be adopted as printed in the handbook carried. (See Board Report, page 544.)

Supplemental Report — Board of Governors

Standardized Claim Form

The motion of the Reference Committee that the portion of the Supplemental Report of the Board of Governors dealing with Standardized Claim Form be filed carried. (See Supplemental Board Report, page 545.)

HEW Release of Physicians Fees

The motion of the Reference Committee that the portion of the Supplemental Report — Board of Governors, dealing with HEW Release of Physicians Fees be filed carried. (See Supplemental Board Report, page 545.)

Medicaid — PMUR Contract

The motion of the Reference Committee that the portion of the Supplemental Report — Board of Governors, dealing with Medicaid-PMUR Contract, be filed, carried. (See Supplemental Board Report, page 546.)

Committee on Health Systems Agencies

Reference Committee No. V read with great interest the report of the Committee on Health Systems Agencies, and was most appreciative of the efforts of Dr. Charles Tate, Chairman. The Committee noted the importance of his testimony regarding physician participation in HSA's.

The motion of the Reference Committee that the report of the Committee on Health Systems Agencies be amended to add the words "and Development" after the word "Planning" and to replace "(SHPA)" with "(SHPDA)," and adopted as amended, carried.

Committee on Health Systems Agencies

Charles F. Tate, M.D., Chairman

During the past Association year, a major priority of the Association has been careful analysis and input for governmental programs such as Public Law 93-641, the National Health Planning and Development Act, with emphasis on HSA's and the State Health Coordinating Council and its Committees. As a part of this effort, a special committee on HSA's, responsible directly to the Board of Governors was appointed. The committee is structured along the same lines as that of the plan adopted by the Minnesota State Medical Association. The objective is to establish a parallel mechanism to that of all state health planning activities, for the purpose of anticipating changes in health planning and whenever possible provide medical input in a constructive manner to insure appropriate health plans are adopted to meet the total needs of the public.

The committee has been dealing on a daily basis with volumes of information regarding: the development of the "State Health Plan," local HSA plans guidelines, "Medical Facilities Plans," "Annual Implementation Plans," and a wide variety of other topics related to health planning and regulations. In order to coordinate input and action at the local HSA level, the committee is composed of a representative and alternate representative from each of Florida's nine HSA areas. Each committee member and alternate has asked a panel of local physicians to work with them in order to monitor the activities of the local HSA and assist in the dissemination of information to local fellow physicians.

There have been two meetings of the committee this Association year. The first meeting established guidelines, policies, and committee functions; the second meeting concentrated on the review of 112 proposed amendments to the National Health Planning Law. A report highlighting those amendments which should be supported by medicine in the best interest of patient care was presented to the Board of Governors.

The committee's second meeting was held immediately following the quarterly meeting of the State Health Coordinating Council (SHCC) thus allowing our committee members to observe and have dialogue with members of the SHCC. In addition to the committee, the staff monitors on a daily basis the activities of the State Health Planning and Development Agency (SHPDA), the HSA Executive Directors Association and the State Health Coordinating Council (SHCC). Also, the staff reviews the activities of a variety of health planning task forces and disseminates pertinent information to each HSA Committee member so that we are appraised of health planning activities on the national, state and local levels.

I am pleased to report that the committees are resulting in a better understanding of the various health planning activities going on in the state as well as allowing greater medical input into the development of health plans, policies and procedures.

Florida Committee on the Cost of Medical Care

The Reference Committee was pleased to read the report on the newly formed Florida Committee on the Cost of Medical Care and was most enthusiastic in their

support of Drs. James F. Richards and Dr. J. Lee Dockery as FMA representatives on this Committee.

The motion of the Reference Committee that the report of the Florida Committee on the Cost of Medical Care be adopted as printed in the handbook carried.

Florida Committee on the Cost of Medical Care

J. Lee Dockery, M.D.

The Board of Governors at its January 1978 meeting authorized the establishment of the Florida Committee on the Cost of Medical Care and outlined the suggested representative organizations to participate.

President Murray requested me to chair the organizational meeting and designated Dr. James F. Richards to serve with me as a representative to the Committee. The Florida Hospital Association agreed to participate and designated Mr. Salvo A. Mudano, Administrator of Memorial Hospital, Hollywood, and Mr. Lee R. Ledbetter, Executive Director, Greater Orange Park Community Hospital, to represent its organization. Blue Cross of Florida, agreeing to participate, designated as its representative G. Emerson Tully, Ph.D., Director, Research Services. Blue Shield of Florida agreed to participate and designated J. Champneys Taylor, M.D., to represent its organization. The Florida State Health Insurance Council agreed to participate and designated Miss Betty Gurney, Prudential Insurance Company, to represent its organization.

The following officers were elected at the formative meeting of the committee held Saturday, March 4, 1978: Chairman — Mr. Salvo Mudano, Vice Chairman — Miss Betty Gurney, and Secretary — J. Champneys Taylor, M.D.

The Committee decided to extend an invitation to representatives of organized labor and industry. The recommendation to appoint a consumer was deferred until the next meeting.

Several facets of possible cost containment were discussed. Among them were pre-admission testing, insurance policy deductibles, out patient insurance coverage, continuing education toward patient awareness of costs and education of physicians by posting costs at hospitals.

The Committee adopted as its prime goal liaison, coordination and education of a program to monitor and evaluate the impact of and the effectiveness of a voluntary cost containment program in Florida.

Each member organization was asked as an immediate plan of the Committee, to prepare an inventory of specific programs and their effectiveness to date, specific goals and plans to implement them in the future.

Resolution No. 78-6, HEW — Release of Physicians' Fees
FMA Board of Governors
and
Resolution No. 78-23, Addendum to Resolution 78-6
HEW Release of Physicians' Fees
Dade County Medical Association

The motion of the Reference Committee that Resolution No. 78-6 be adopted as printed in the handbook carried.

In line 1, of Resolution 78-23, following the word "Association," the Reference Committee added the words "consider the feasibility of" and changed the word "purchase" to "purchasing," line 2.

The motion of the Reference Committee that Resolution 78-23 be so amended and adopted as amended carried.

RESOLUTION 78-6

HEW — Release of Physicians' Fees

RESOLVED, That the Florida Medical Association totally and emphatically reject HEW's release of physicians' fees under Medicare for assigned and unassigned claims as being totally unjustified, a willful violation of privacy, and not in concert with the law, be it further

RESOLVED, That every possible legal recourse be pursued to have this regulation set aside, and be it further

RESOLVED, That Florida's delegates to the AMA be requested to submit this resolution to the AMA House of Delegates for consideration of adoption at the earliest possible date.

RESOLUTION 78-23

Addendum to Resolution 78-6

RESOLVED, That the Florida Medical Association consider the feasibility of purchasing advertising space in major Florida newspapers (timed to appear the precise day that the published HEW data is released) so as to appropriately "inform" the public.

Resolution No. 78-11
Publication of Medicare Payments
Pinellas County Medical Society

In the first paragraph, an amendment was offered to change the words "said doctor" to "his or her." The motion of the Reference Committee that Resolution No. 78-11 be so amended and adopted as amended carried.

RESOLUTION 78-11

Publication of Medicare Payments

RESOLVED, That the Florida Medical Association, through the Florida Medical Foundation call upon Blue Shield to supply to each doctor a list of all recipients of his or her services under the Medicare program, and be it further

RESOLVED, That this list include the amount of payment made to each recipient, and be it further

RESOLVED, That the list include the amount of payment made to each recipient under assignment in each recipient's behalf.

Resolution 78-15
Blue Shield of Florida
Dade County Medical Association

The motion of the Reference Committee that Resolution 78-15 be adopted carried.

RESOLUTION 78-15

Blue Shield of Florida

RESOLVED, That the House of Delegates of the Florida Medical Association continues its pledge of support and expresses its

confidence in the Board of Directors and the Staff of Blue Shield of Florida.

Resolution 78-17
Review of Governmental Health Care Programs
Brevard County Medical Society

The motion of the Reference Committee that Resolution 78-17 be adopted carried.

RESOLUTION 78-17

Review of Governmental Health Care Programs

RESOLVED, That the FMA recommend to the AMA that the AMA petition the U.S. Government, **by lawsuit if necessary**, to provide all documentation necessary for determination by non-governmental review as to whether or not the health care provided within the framework of the U.S. Veterans Administration Hospital System and V.A. outpatient clinics, the U.S. Public Health Service Hospital System, and the U.S. Peacetime Military Health Care System meets the criteria of accountability and performance which now are imposed by the U.S. Federal Government upon the private or non-governmental sector providing health care in the U.S.A.

RESOLUTION 78-20
HEW Release of Physician Fees
Dade County Medical Association

The Reference Committee was of the opinion that the intent of Resolution 78-20 was covered in Resolution 78-23.

The motion of the Reference Committee that Resolution No. 78-20 not be adopted failed to carry.

A motion to refer Resolution 78-20 to the Board of Governors failed to carry. The motion that Resolution 78-20 be adopted carried.

RESOLUTION 78-20

HEW — Release of Physicians' Fees

RESOLVED, That the Florida Medical Association and its members notify HEW and its Florida Medicare carriers that there may indeed have been some false non-assignment claims payments and that the physicians of Florida are unable to vouchsafe the accuracy of any non-assignment payment figures.

Resolution 78-25
Health Insurance Claim Forms
James L. Borland, M.D.

The motion of the Reference Committee that Resolution 78-25 be adopted carried.

RESOLUTION 78-25

Health Insurance Claim Forms

RESOLVED, That the Florida Medical Association communicate to the insurance commissioner of the State of Florida the urgent need for removing the prohibition of such attachments to the health insurance claim form (as amended to meet Florida's specific requirements — March 1978), and be it further

RESOLVED, That the Florida Medical Association petition the Florida Hospital Association to join in this request to the Insurance Commissioner, and be it further

RESOLVED, That due to the planned implementation of this act on July 1, 1978, these resolves be carried out immediately.

The Chairman of the Reference Committee wished the House of Delegates to know that he chaired a conscientious and hardworking group, and wished to thank Charles P. Hayes, M.D., George Messenger, M.D., Maurice H. Laszlo, M.D., and James Schoeck, M.D., and a special thanks was given to Charles K. Donegan, M.D., AMA Delegate Advisor, in appreciation for his competent counsel. Reference Committee V expressed their gratitude at having Mr. Gene Johnson, FMA staff, and thanked Ms. Marcia Protheroe, Recording Secretary, for her assistance and skilled efforts in helping to prepare this report.

The motion of the Reference Committee that the report of Reference Committee V be adopted as a whole as amended carried.

Report of Reference Committee No. IV Legislation and Miscellaneous

Dr. Dick Van Eldik, Chairman, and his committee came forward to present the report of Reference Committee No. IV, Legislation and Miscellaneous.

The Reference Committee reported that each of the items referred to it had been considered and testimony was heard from many members of the FMA regarding these issues. The presentation and advice by James B. Perry, M.D., Chairman of the Council on Legislation and Regulations, was particularly helpful and enlightening.

The Committee publicly commended Dr. Perry for his outstanding work in his role as Chairman of this Council. Further, the Committee gave recognition to Mr. Donald S. Fraser, Jr., Director of Legislative Affairs and to Mr. George S. Palmer, Jr., Manager of the FMA Capital Office, and the entire Tallahassee staff. The Committee recognized the contributions of all members of the FMA who have participated in the FMA legislative activities during the past year.

Council on Legislation and Regulations

The report of the Council on Legislation and Regulations was reviewed by the Reference Committee. The Committee studied each item carefully and expressed its appreciation to the Council for its action.

The Reference Committee heard testimony from Jere W. Annis, M.D., Trustee of the AMA, and Joseph C. Von Thron, M.D., FMA Delegate to the AMA, regarding the FMA's position on the AMA National Health Insurance Bill.

The Reference Committee moved that a substitute for the sixth paragraph of the Council's report be adopted. The motion of the Reference Committee carried.

The motion of the Reference Committee that since HR 1818 is due to expire at the end of December, a finalized copy of any new bill adopted by the AMA should be referred to the FMA House of Delegates for consideration carried.

The motion of the Reference Committee that the report of the Council on Legislation and Regulations be adopted as amended carried.

Council on Legislation and Regulations

James B. Perry, M.D., Chairman

Most of the work of the Council on Legislation and Regulations is accomplished through activities of its two committees: the Committee on State Legislation and the Committee on National Legislation. The report of your Council is submitted as individual reports of the two committees.

Committee on National Legislation — This committee consists of the key contact physicians for each member of the Florida delegation of the U.S. Senate and the U.S. House of Representatives. Members of this committee have kept in close touch with their assigned



Legislative and miscellaneous matters were considered by Reference Committee IV. Left to right: Dick L. Van Eldik, M.D., Lake Worth, Chairman; Ms. Nancy Hendricks, Jacksonville, Recording Secretary; Irving Essrig, M.D., Tampa; Joseph H. Davis, M.D., Miami; George N. Lewis, M.D., Tallahassee; and H. Quillian Jones, M.D., Fort Myers.

Senators and Congressmen on national legislative matters of interest to the FMA and American Medical Association.

The Association has been very active on the national legislative scene during the past year. The AMA has established a mechanism of regular telephone conferences on issues of critical concern. This has enabled contact physicians and FMA staff to more effectively respond at the proper time to influence legislative action.

Among the issues that were subject to this action were:

1. Medicaid and Medicare Fraud and Abuse Amendments (HR 3)
2. Legislation to give Federal Trade Commission authority over non-profit organizations (HR 3816).
3. Carter Administration proposal on hospital cost containment.
4. Clinical Laboratory Act Amendments.
5. Physician Extender Legislation.
6. Certificate of Need for physicians' office equipment and other amendments to PL 93-641 (HR 10460).

Particularly significant has been the scheduling of regular discussion with Congressman Paul Rogers. Through this liaison, the Association was able to gain his support for deleting the requirement for Certificate of Need for physicians' offices from the House version of the hospital cost containment bill.

Since HR 1818, which is the present AMA-sponsored bill, will expire on December 31, 1978, and therefore, because National Health Insurance is a continuing matter of concern, we encourage the House to instruct its delegates to the American Medical Association to exercise their individual and/or collective knowledge and experience to either support, modify, reject, or assist in the development of any AMA bill relating to National Health Insurance.

Major effort will be directed at getting necessary amendments to PL 93-641. Among the amendments advocated by the FMA are elimination of the category of "indirect provider" on the SHCC and HSA governing boards and defeat of proposals to require certificate of need for physicians' office equipment.

Committee on State Legislation — The Committee has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized specialty groups. Three formal meetings of the committee have been held, along with informal conferences among committee members as items of an urgent nature arose.

Consistent with the policies developed by the FMA House of Delegates the committee has worked closely with the Board of Governors in developing our legislative program for the 1978 session of the Florida Legislature.

The following items summarize the committee's activities:

1. The legislative program is continuing to function under the supervision of Donald S. Fraser Jr., Director of Legislative Affairs. He has been materially assisted by George S. Palmer Jr., Manager of the Capital Office, Mrs. Nancy Moreau, Legislative Analyst, and Phil Gilbert, Director of FMA Government Programs Department. Particularly helpful to the legislative activity has been the establishment of the FMA Branch Offices in Central and South Florida. These have greatly increased the Association's ability to maintain liaison with county medical societies, contact physicians, and members of the Legislature.

2. The Capitol Dispensary — The Committee has continued to place major emphasis on working with the Capitol Dispensary which has proven to be most important in meeting the needs of legislators and their staffs. Mrs. Delma Hart, R.N., has continued to provide excellent assistance to the FMA in coordinating the activities of the Dispensary for the Doctor of the Day Program.

3. The Committee on State Legislation is continuing to emphasize the need to develop a good key contact physician program in each county medical society in the state. A program has been undertaken to work with each county medical society in reviewing their assigned key contact physicians to make sure that the best possible physician is assigned this critical task.

4. Publications — A legislative bulletin was published every week during the legislative session and periodically between sessions. The bulletin is designed to give up-to-date information to members of the FMA who are involved in legislative activities. A special publication has been instituted to communicate with members of the FMA on the current status of the Emphasis '78 legislative effort. This special publication will be mailed on a regular basis in addition to the legislative bulletin.

5. 1977 Legislative Accomplishments — During the 1977 legislative session, there were more that 400 legislative proposals that required action by the state legislative committee or the Capital Office staff. Matters of major interest to the Florida Medical Association were:

—Re-enactment of 1976 Tort Reforms that were declared unconstitutional by Leon County Circuit Court.
—Passage of legislation to require physician supervision of EMT IIs.
—Defeat of legislation to require certificate of need for physicians' office equipment.
—Defeat of legislation to grant limited hospital privileges to chiropractors.
—Defeat of legislation to place a consumer on State Board of Medical Examiners.
—Defeat of legislation to establish hospital medical incident committees.
—Defeat of licensure requirement for radiologic technologists and others using x-ray equipment.
—Defeat of restrictive physician's fee schedule for workmen's compensation.

6. Constitution Revision Commission — Major emphasis by staff and contact physicians was directed toward getting a Cabinet level department of health placed in the proposed revision to Florida's Constitution. While failing to gain majority for an elected Secretary of Health, the Association was successful in generating sufficient support to get the following language placed in the document:

> "Section 11. Department of health. — There shall be a department of health, the head of which shall be a physician with training in public health who is appointed by the governor and confirmed by the senate. The department shall have supervision of matters pertaining to the protection and promotion of the health of the people of Florida as prescribed by law."

7. Major legislative priorities for the 1978 Session — The major legislative objectives for the 1978 Session of the Florida Legislature as established by the FMA House of Delegates and the Board of Governors are:

—Legislation to implement the constitutional requirement for a separate department of health.
—Provision for recovery of defense costs in medical malpractice cases.

Other important legislative objectives will include:

—Increased funding for the State Board of Medical Examiners.
—Revision of the Medicaid program, particularly in the area of total funding.
—Defeat of legislation to regulate doctor's office equipment through the certificate of need process.
—Defeat of proposal that would require physicians and other health care providers to disclose ownership in hospital and other health care facilities on an annual basis to the Department of Health and Rehabilitative Services, as well as furnish to each patient a disclosure of such ownership (HB 547).
—Defeat of proposal that would include a requirement that all persons who administer x-rays in the State of Florida be licensed by the proposed board (HB 22).

—Defeat of attempts to weaken the State Board of Medical Examiners.
—Defeat of legislation to grant limited hospital staff privileges to chiropractors.
—Defeat of legislative enactment of a structured fee schedule under the Workmen's Compensation program.
—Defeat of legislation to establish a State Commission to regulate hospital and nursing home rates.
—Defeat of legislation to abolish mediation panels (HB 419).
—Defeat of legislation providing non-judicial mandatory hospital compensation committees.

A supplemental report will be prepared by the Committee on State Legislation and distributed prior to the first session of the House of Delegates. This supplemental report will outline up-to-date progress of the FMA legislative program made during the 1978 Legislative Session. It will also include other important state legislative items which might develop prior to the FMA Annual Meeting.

Supplemental Report

Council on Legislation and Regulations

Under Item No. 3, the Reference Committee heard considerable testimony regarding background information and funding. It was noted that there was a $1,000,000 Trust Fund from the physicians of Florida, which is unavailable for the Board of Medical Examiners' use.

The motion of the Reference Committee that the FMA, through the appropriate legislative channels, take action to assure that the necessary funds be budgeted so that the Board of Medical Examiners can effectively perform its necessary disciplinary functions carried.

Under Item No. 5, Paragraph C, the Reference Committee expressed its vigorous opposition to HB 222 and SB 992.

On Paragraph D, the Reference Committee expressed its vigorous support of the functions of the State Board of Medical Examiners and opposed any attempts to weaken its effectiveness.

The motion of the Reference Committee that the Florida Medical Association oppose any legislation concerning the abolishment of mediation panels carried.

In Paragraph I, the Reference Committee acknowledged that there are qualified osteopathic physicians currently having difficulty acquiring hospital privileges.

The Reference Committee moved that the House reaffirm the FMA's established philosophy that, if osteopathic physicians have adequate qualifications, there should be no discrimination. A substitute motion to delete this motion from the Reference Committee Report and accept that portion of the Council's Supplemental Report for information only failed to carry. The Reference Committee's original motion carried.

On Paragraph J, the Reference Committee expressed its opposition to civil penalties for doctors adding to charges made by laboratories.

On Paragraph K, the Reference Committee expressed vigorous opposition to this legislation.

On Paragraph L, the Reference Committee expressed opposition to any major revision to the Nurse Practice Act.

On Paragraph N, the Reference Committee requested continued opposition to the licensure of respiratory care therapists.

On Paragraph O, the Reference Committee urges the continued opposition of legislation which would create a statutory definition of death.

On Paragraph P, the Reference Committee opposed legislation which would allow county health departments to establish prepaid health care service plans.

On Paragraph Q, it was the Reference Committee's understanding that the bill in its final form is not acceptable.

The Reference Committee heard testimony regarding HB 1155 and SB 1220 and held considerable discussion regarding them.

The motion of the Reference Committee that the FMA support HB 1155 and SB 1220 with the deletion of that portion that allows the interruption of pregnancy in an office or an out-patient facility during the second trimester, a needless hazard to the mother, carried.

On Paragraph R, the Reference Committee expressed strong opposition to HB 1328 as written.

On Paragraph S, the Reference Committee expressed strong opposition to HB 1415 as written.

On Paragraph T, the Reference Committee expressed strong opposition to HB 1524 and SB 1061.

On Paragraph V, the Reference Committee expressed strong opposition to HB 1708.



"Harvey — Cardiac Patient Simulator" was awarded first place in the scientific exhibit competition. Here a physician examines Harvey, a manikin programmed to exhibit signs of various types of heart disease, as the exhibit's technical director looks on. Harvey was entered by Michael S. Gordon, M.D., Ph.D., of the University of Miami School of Medicine.

On Paragraph W, the Reference Committee expressed strong opposition to the regulation of the use of electroconvulsive therapy and psychosurgery.

Dr. Perry, Chairman of the Council on Legislation and Regulations, pointed out to the Reference Committee that in the next year, the following three items would be of great importance to the physicians of Florida:

1. Implementation of a Separate Department of Health, if the amendment establishing such a Department is passed.

2. Careful monitoring of any bills regarding cost containment.

3. Careful monitoring of the erosion of physician practices by paramedical legislation.

The motion of the Reference Committee that the Supplemental Report of the Council on Legislation and Regulations be adopted carried.

Supplemental Report

Council on Legislation and Regulations

James B. Perry, M.D., Chairman

This is to update the report of the Council on Legislation and Regulations printed in the Delegates handbook. This report reflects the status of legislation as of April 26, 1978.

Legislative Status of FMA 1978 Legislative Program

1. Legislation to Implement Constitution Revision Provision for a Department of Health — No legislation has been introduced as of this date which would implement the constitutional requirement for a Department of Health. Conferences with legislative leaders have indicated that staff work has already begun on cataloguing the health functions that will be transferred under the provisions of the constitutional mandate. A draft bill has been prepared by FMA staff and consultants to be used as a vehicle for seeking passage of the required implementing bill during the 1979 legislative session.

2. Recovery of Defense Costs — Legislation has been filed in both the House and the Senate which would allow for recovery of defense costs, as well as attorney fees in medical malpractice actions. The House bill, HB 1756, by Culbreath, has been referred to the Committee on Commerce. The Senate bill is SB 1242, by Glisson. In addition to the FMA sponsored bill, there is legislation pending on the House Calendar by Representative Barry Richard (D-Dade) which would allow for recovery of costs, HB 1062. The Senate companion, SB 980, filed by Senator Tom Gallen (D-Manatee), is in the Senate Judiciary Civil Committee.

3. Increased Funding for the State Board of Medical Examiners — While the final Appropriations Bill has not been approved by the Legislature, the committees in both the House and Senate have recommended substantial increases in funding for the State Board of Medical Examiners. The Senate bill calls for an increase of three investigators and a $37,371 increase in legal fees. In addition, the Senate bill provides fo $141,125 to allow Florida to go to the FLEX examination. The House Appropriations Committee has recommended three investigators, one secretary, a $54,000 increase in legal fees, plus $141,125 to allow Florida to go to the FLEX examination.

4. Revision of Medicaid Program Particularly in the Area of Total Funding — The House version appropriates an increase of $49,072,416 for the total program and $29,370,331 for an increase in physicians services. The figures in the Senate Appropriations Bill are not available.

5. Status of Other Issues of Concern to Florida Physicians.

a. Regulation of doctors' office equipment through the certificate of need process. By a vote of 9-3, the House HRS Committee killed a proposal which would have placed certificate of need provision for doctors' office equipment purchases. There is no comparison legislation pending at the current time in the Senate.

b. Truth in sickness legislation (HB 547, SB 466). The proposed House bill, HB 547, has been reported unfavorably by the HRS Subcommittee on Health and Mental Health. The Senate version, SB 466 was amended by the Senate HRS Committee to delete the requirements for financial disclosure by physicians.

c. Licensure of radiologic technologists. Legislation has been filed in both the House and Senate (HB 222, SB 992). Neither of these bills have been heard by committee.

d. Attempts to weaken the State Board of Medical Examiners. A substantial number of bills have been filed which would weaken the authority of the SBME. As of this date, none of these bills have been reported out of committee. In addition to several bills setting up temporary licensure procedures, legislation has been filed to place two nurses on the SBME (SB 442, HB 1372), and bills to place consumers on occupational and professional boards (SB 556, HB 28). A bill has been filed in the House (HB 1552) which would create a "super board" for all licensing boards under the Department of Professional and Occupational Regulation. If passed, the legislation would have the practical impact of creating advisory bodies out of existing licensure boards and giving the ultimate authority to the Department of Professional and Occupational Regulation.

e. Legislative enactment of a structure fee schedule under the Workmen's Compensation program. At the present time, both the House and Senate Commerce Committees are conducting extensive hearings into the workmen's compensation program. Some of the proposals include additional regulations on physician fees, but as of this date, no proposed committee bills have been finalized.

f. State commission to regulate hospitals and nursing home rates. Bills have been filed in both the House and the Senate which would set up a state commission to regulate the rate increases of hospitals. As has been the case in other states, the commission would have the indirect authority to regulate the relationships between hospitals and hospital-based physicians. The House bill, HB 1706 has been referred to the Committee on Regulated Industries. The Senate companion, SB 1174, has been referred to HRS, Governmental Operations, and Appropriations Committees.

g. Abolishment of mediation panels. This legislation, HB 419, is still in the House Commerce Committee.

h. Extension of JUA. The Senate version of the bill, SB 481, is on the Senate calendar. The House version adopted by the House Committee on Commerce has not yet been given a number but should be on the House Calendar soon.

i. Mandatory hospital privileges for osteopaths. The Senate version, SB 607 has been referred to the Committee on HRS. The House bill, HB 1306 has been referred to the Committee on HRS.

j. Civil penalties for doctors adding to charges made by labs. This legislation is still in committee with the Senate version, SB 697, being in HRS and Judiciary Civil Committees, and the House version, HB 1497, in the Committee on Judiciary.

k. Medicaid reimbursement for nurse midwife services. This bill was reported out favorably by the Senate Committee on HRS but was left pending because of a motion to reconsider. The bill is also referred to Appropriations.

l. Major revision to the Nurse Practice Act. This bill, SB 1038, makes revisions to the Nurse Practice Act, including the elimination of

the joint committee of the State Board of Medical Examiners and the State Board of Nursing. It is referred to the Committee on HRS, Governmental Operations, and Appropriations.

m. Expanded authority of the State Board of Medical Examiners. The House of Representatives has passed the House companion, HB 601 and it is now on the Senate Calendar.

n Licensure of respiratory care therapists. This legislation, HB 796, has been referred to the Committees on Regulated Industries and Appropriations.

o. Definition of death. Legislation has been filed in the House, HB 1069, and in the Senate, SB 1130, which would create a statutory definition of death. The House bill is in HRS and the Senate bill is in Judiciary/Civil Committee.

p. County health departments prepaid health care plans. Legislation has been filed to allow county health departments to establish prepaid health care service plans. HB 1116 is in HRS and Appropriations and the Senate companion, SB 1034 is in HRS and Appropriations Committees.

q. Regulation of abortion clinics. The House version, HB 1155, is in the Committee on HRS. The Senate version is SB 1220.

r. Access to doctors' office records (HB 1328). This bill requires physicians to furnish their records to a patient or upon written authorization to his guardian, curator, or personal representative. It has been referred to Regulated Industries and Licensing.

s. Fine for failure to provide medical reports (HB 1415). This legislation provides a jail term of up to 60 days and a fine of up to $500 for any physician failing to furnish a medical report upon request of a patient or his personal representative. It has been referred to Regulated Industries.

t. Mandatory chiropractic insurance coverage. HB 1524 has been referred to the Committee on Commerce and the Senate version, SB 1061, has been referred to Commerce Committee.

u. Revisions to drug substition law. Legislation revising Florida's drug substitution law has been filed in both the House and the Senate. The House version, HB 1605, is in the Committee on HRS. The Senate version is SB 1201.

v. Mandatory core public health program (HB 1708) This bill requires the Department of HRS to set up a "health care delivery system." In addition, it mandates a minimum program that each county health department must carry out. The prinicpal objective of the bill appears to be a state takeover of local county health programs. It has been referred to HRS.

w. Regulation of use of electroconvulsive therapy and psychosurgery. The House version, HB 1752, has been referred to HRS and the Senate version, SB 1014, has been referred to HRS.

6. Other Late Developing Legislative Activities — The Council would ask for permission to introduce to the Reference Committee any item of major significance that might have arisen in the Legislature between April 26th and the time of the FMA meeting.

BOARD OF GOVERNORS REPORT

Board Actions of Major Importance

Separate Department of Health

The motion of the Reference Committee that the Board of Governors report on a Separate Department of Health be adopted as printed in the handbook carried. (See Board Report, page 532.)

Recovery of Defense Cost

The motion of the Reference Committee that the Board of Governors report on the Recovery of Defense Cost be adopted as printed in the handbook carried. (See Board Report, page 532.)

Drug Inserts

The motion of the Reference Committee that the Board of Governors report on Drug Inserts be adopted as printed in the handbook carried. (See Board Report, page 536.)

FMA Councils and Committees Section

Council on Legislation and Regulations

In considering the Board of Governors Report on the Council on Legislation and Regulations, the Reference Committee suggested that the Board of Governors study the possibility of extending the jurisdiction of the mediation panels to contiguous areas.

The Reference Committee also suggested that the Board of Governors request the Editor of *The Journal* of the Florida Medical Association to invite each candidate for Governor of the State of Florida to submit an article for publication regarding his philosophy concerning health care.

The motion of the Reference Committee that the Board of Governors Report on the Council on Legislation and Regulations be adopted as printed in the handbook carried. (See Board Report, page 542.)

Resolution 78-3

Confidentiality of Medical Records

Pinellas County Medical Society

The Reference Committee heard extensive testimony and carefully deliberated this matter.

The Reference Committee moved that Resolution 78-3, Confidentiality of Medical Records, not be adopted.

A substitute motion to refer Resolution 78-3, Confidentiality of Medical Records to the Board of Governors for study carried.

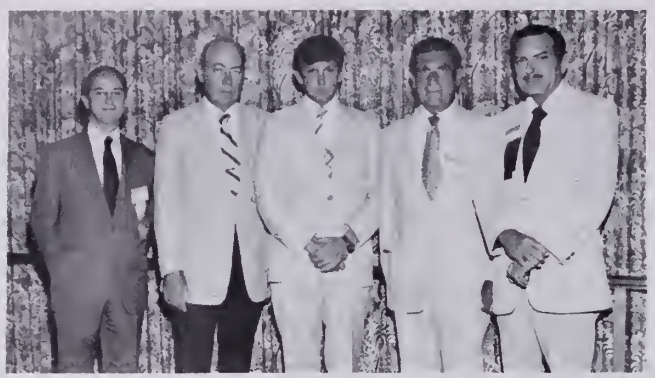
RESOLUTION 78-3

Confidentiality of Medical Records

Pinellas County Medical Society

[NOT ADOPTED — Referred to the Board of Governors]

Whereas, Medical insurance companies and other third party health payers are demanding increasing numbers of entire patient



The FMA Council on Scientific Activities hosted the annual Deans' Luncheon on Thursday of the Annual Meeting. Left to right: William B. Deal, M.D., Gainesville, Vice President for Health Affairs and Dean of the University of Florida College of Medicine; FMA President Louis C. Murray, M.D., Orlando; Council Chairman Yank D. Coble Jr., M.D., Jacksonville; Emanuel M. Papper, M.D., Miami, Vice President and Dean of the University of Miami School of Medicine; and FMA President-Elect O. William Davenport, M.D., Miami.

hospital records which are duplicated and sent to the third party health payers, and

Whereas, The record copies are then warehoused for two, three or more years under only minimum to moderate security, and

Whereas, Third party payers have seemingly blackmailed hospitals into releasing copies of these entire records on the grounds that the patient's insurance contract will not be honored, and

Whereas, The individual patient is coerced into signing a blanket uniform release of information form in order to be admitted to the hospital, therefore be it

RESOLVED, That the FMA in collaboration with county and specialty societies formulate a model statute to be presented to the state legislature forbidding the duplication or sending of any part of any hospital patient records with the exception of the face sheet, summary and E.R. report, to any third party payer or fiscal intermediary company, and be it further

RESOLVED, That the FMA continue its endeavors to protect the confidentiality of medical and psychiatric patient records in clinics, private offices, and other health agencies as well as in hospitals.

Resolution 78-4

Expert Witnesses

Pinellas County Medical Society

The Reference Committee considered Resolution 78-4, Expert Witnesses, and proposed to amend the Resolution by adding two additional Resolveds. A motion from the floor to amend the Reference Committee motion by deleting the second Resolved of the Reference Committee's amendment carried.

The motion to adopt Resolution 78-4, Expert Witnesses as amended carried.

RESOLUTION 78-4

Expert Witnesses

RESOLVED, That the Florida Medical Association condemn those physicians who interfere with the proper administration of justice by giving false or misleading testimony or misrepresenting their qualifications, and be it further

RESOLVED, That the Florida Medical Association urge the courts to refuse to admit as expert testimony the testimony of those physicians who do not have clear cut qualifications as recognized by their peers, and be it further

RESOLVED, That the Florida Medical Association urge county medical societies to initiate disciplinary action before the appropriate medical licensure board when physicians testify without having a current basic educational and professional knowledge, testify falsely, or give deliberately misleading testimony, and be it further

RESOLVED, That the Florida Medical Association seek a legislative definition of acceptable expert witnesses, and be it further

RESOLVED, That the Florida Medical Association seek to establish a system of monitoring the activities of expert witnesses on mediation panels and in the courts.

Resolution 78-5

Midwifery

Pinellas County Medical Society

The Reference Committee heard extensive testimony and carefully deliberated this matter.

The motion of the Reference Committee that Resolution 78-5, Midwifery, be adopted as printed in the handbook carried.

RESOLUTION 78-5

Midwifery

RESOLVED, That the Florida Medical Association actively support SB 120 Midwifery and any House companion bill submitted to the House of Representatives, and be it further

RESOLVED, That the Florida Medical Association direct efforts toward upgrading HRS rules and standards of qualification to those of at least a registered nurse.

Resolution 78-7

Hospital Tax District Legislation

Pinellas County Medical Society

After much discussion, it was felt that the problem presented in this resolution was not peculiar to Pinellas County Medical Society, and there may be other counties attempting to solve this problem.

The motion of the Reference Committee that Resolution 78-7, Hospital Tax District Legislation, be referred to the Board of Governors for study and evaluation, carried.

RESOLUTION 78-7

Hospital Tax District Legislation

Pinellas County Medical Society

[NOT ADOPTED — Referred to the Board of Governors]

Whereas, Hospitals in Pinellas County are called upon to treat a large number of persons without financial resources, and

Whereas, Pinellas County government has been able to offer only small partial reimbursement, and

Whereas, Florida state law allows but does not require each County to set up a Hospital Taxing District, and

Whereas, Many of the more populous counties, including Hillsborough, have availed themselves of this source of funds, and

Whereas, Public Referendum in Pinellas County has defeated this proposal in the past, and is likely to do so again, therefore be it

RESOLVED, That Legislative action be initiated to require Pinellas County to set up a Hospital Taxing District to solve this problem, and be it further

RESOLVED, That the Florida Medical Association support any local Tax District Legislation originating in Pinellas County.

Resolution 78-16

Mediation Panel Questionnaires

Hillsborough County Medical Association

After appropriate testimony from interested members, the Committee evaluated this problem.

The motion of the Reference Committee that Resolution 78-16, Mediation Panel Questionnaires, be referred to the Board of Governors, carried.

RESOLUTION 78-16

Mediation Panel Questionnaires

Hillsborough County Medical Association

[NOT ADOPTED — Referred to the Board of Governors]

Whereas, At least one judicial circuit has adopted a supplemental questionnaire for prospective mediation panel physician members, and

Whereas, Such a questionnaire has propounded complex personal and unanswerable questions, and

Whereas, Such questionnaire goes beyond seeking information necessary to identify personal bias, and

Whereas, Such a questionnaire further discourages physician participation in mediation panels, therefore, be it

RESOLVED, By the Florida Medical Association that the Supreme Court of Florida be requested to review such supplemental questionnaires for prospective mediation panel members with a view to determining their appropriateness and advising the chief judge of the subject circuit, and that a copy of this resolution be forwarded to the Honorable Arthur England, Chief Justice of the Supreme Court of Florida.

Resolution 78-22

Support for HB 400 and SB 538 Would Exempt Certain Health Care Providers From Civil Liability in Charity Clinics

Dade County Medical Association

The motion of the Reference Committee that Resolution 78-22, Support for HB 400 and SB 548 Would Exempt Certain Health Care Providers from Civil Liability in Charity Clinics be amended by re-wording the last line, carried.

The motion of the Reference Committee that Resolution 78-22 be adopted as amended carried.

RESOLUTION 78-22

Support for HB 400 and SB 538 Which Would Exempt Certain Health Care Providers from Civil Liability in Charity Clinics

RESOLVED, That the Florida Medical Association vigorously support HB 400 and SB 538 which will exempt health-care providers (including licensed physicians, registered nurses, clinical laboratory personnel, etc.) from civil liability for free medical services.

Resolution 78-24

Relative Value Studies

Samuel M. Day, M.D.

The motion of the Reference Committee that Resolution 78-24, Relative Value Studies, be adopted as printed carried.

RESOLUTION 78-24

Relative Value Studies

RESOLVED, That the Congress of the United States be urged to make necessary revisions in the laws to overturn the recent actions of the Federal Trade Commission in outlawing various Relative Value Schedules, and be it further

RESOLVED, That this resolution be referred by our Delegates to the AMA House of Delegates, requesting AMA support for our position.

The Chairman thanked the members of the Committee: Joseph H. Davis, M.D., Irving Essrig, M.D., H. Quillian Jones, M.D., and George N. Lewis, M.D.; the AMA Delegate Advisor, Joseph C. Von Thron, M.D.; the members who came to speak before the Committee; and Ms. Nancy Hendricks, who served as the secretary for the Committee. He stated that without the efforts, assistance, and cooperation of all of the above, this report would not have been possible.

The motion of the Reference Committee that the Report of Reference Committee IV be adopted as a whole as amended carried.

This concluded the report of Reference Committee IV.

The Second Meeting of the House of Delegates recessed at 5:55 p.m. to reconvene Sunday morning at 9:00 a.m.

Annual Meeting

1, Facing camera: Dr. and Mrs. Daniel B. Nunn and daughter, Myra Beth, and other guests at President's Reception; 2, Dr. Yank D. Coble Jr., and Dr. and Mrs. Henry M. Yonge; 3, Drs. William W. Thompson, Louis C. Murray and Richard B. Moore; 4, Dr. Wilson T. Sowder and former Gov. LeRoy Collins; 5, Dr. Dick L. Van Eldik; 6, Drs. Rufus K. Broadaway and O. William Davenport, Mrs. Richard B. Moore and Dr. Moore; 7, former Gov. Haydon Burns and Mr. Claude Kirk Sr.; 8, Drs. Sarah C. Schulz and James T. Cook; 9, Drs. E. M. Papper and William B. Deal and Mrs. Richard B. Moore; 10, Mr. Claude Kirk Sr., Dr. Wilson T. Sowder, former Gov. LeRoy Collins, Dr. Louis C. Murray, and former Gov. Haydon Burns; 11, Mrs. John W. Glotfelty and Mr. William Elsner; 12, Dr. Sanford A. Mullen; 13, Drs. W. Harold Parham, O. William Davenport and Louis C. Murray; 14, Dr. James T. Cook; 15, Drs. Charles K. Donegan, Burns A. Dobbins, and Jere W. Annis.





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Pictorial Highlights


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DIPLOMAT
HOTEL
HOLLYWOOD FLA.


DIPLOMAT
HOTEL
HOLLYWOOD FLA.
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16, Dr. and Mrs. Louis C. Murray and daughter, Mary Rose; 17, Dr. H. Q. Jones and Dr. and Mrs. W. Dean Steward; 18, Dr. William B. Deal; 19, Drs. Edward W. Stoner and T. Byron Thames and Mrs. Louis C. Murray; 20, Dr. J. Lee Dockery, Mrs. Carolyn K. Kenyon and Dr. Eugene Peek Jr.; 21, Dr. and Mrs. Gerold L. Schiebler; 22, Mrs. Joseph C. Von Thron, Dr. and Mrs. Jack A. MaCris, and Dr. Von Thron; 23, Drs. John W. Glotfelty and Louis C. Murray; 24, Drs. Eugene Peek Jr. and E. Charlton Prather; 25, Drs. Edward St. Mary and Louis C. Murray; 26, Dr. Floyd K. Hurt and Dr. and Mrs. H. Phillip Hampton; 27, Drs. Clyde M. Collins, Daniel B. Nunn and Louis C. Murray; 28, Mrs. Jere W. Annis, Dr. Charles K. Donegan, and Dr. and Mrs. Thad Moseley; 29, Mrs. Yank D. Coble Jr. and Mrs. Louise Rader.

Third House of Delegates

The third meeting of the House of Delegates convened at 9:00 a.m. on Sunday, May 7, 1978, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with the Speaker of the House, Dr. Charles J. Kahn, presiding.

Dr. John Glotfelty, Chairman of the Credentials Committee, reported 219 delegates were registered representing 37 county societies, which constituted a quorum, and moved that the delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; William B. Deal, M.D.; James C. Garlington, M.D.; Douglas O. Jenkins, M.D.; William W. Pfaff, M.D.; Gerold Schiebler, M.D.; James Campbell, Student Delegate; (Absent — Thomas D. Bartley, M.D.)

BAY — Philip Cotton, M.D.; James D. Nixon, M.D.

BREVARD — Richard N. Baney, M.D.; Michael J. Foley, M.D.; Edwin E. Hadden, M.D.; Laudie E. McHenry, M.D.; Howard W. Pettengill, M.D.; Burton Podnos, M.D.

BROWARD — Charles M. Bonura, M.D.; Robert J. Brennan, M.D.; Bruce B. Burgess, M.D.; Andre S. Capi, M.D.; Burns A. Dobbins, M.D.; Arthur L. Eberly, M.D.; Theodore W. Hahn, M.D.; William C. Hartley, M.D.; David C. Lane, M.D.; George P. Messenger, M.D.; James B. Perry, M.D.; Thomas F. Regan, M.D.; Joseph M. Sachs, M.D.; Norbert Skaja, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; Juan S. A. Wester, M.D.; (Absent — Robert L. Andreae, M.D.; Charles H. Bechert II, M.D.; Russell B. Carson, M.D.; Phillip A. Caruso, M.D.; Milton P. Caster, M.D.; Willis N. Dickens, M.D.; Richard S. Doyle, M.D.; Gary Gieseke, M.D.; Floyd A. Osterman, M.D.; Raymond E. Parks, M.D.; Ernest G. Sayfie, M.D., Diran M. Seropian, M.D.)

CAPITAL — Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Melvyn J. Katzen, M.D.; (Absent — Thomas R. Civitella, M.D.)

CITRUS-HERNANDO — James J. Cuffe, M.D.; W. Randall Jenkins, M.D.

CLAY — Laurin G. Smith, M.D.

COLLIER — Virgil A. Ponzoli Jr., M.D.; Donald Q. Vining, M.D.; (Absent — Robert J. Wald, M.D.)

COLUMBIA — Henry E. Plenge, M.D.

DADE — Manuel Abella, M.D.; Seymour Alterman, M.D.; Edward Annis, M.D.; Robert L. Bishany, M.D.; Jose S. Bocles, M.D.; Rufus K. Broadaway, M.D.; Luis A. Cabrera, M.D.; Manuel L. Carbonell, M.D.; Sol Center, M.D.; Richard C. Clay, M.D.; Jack Q. Cleveland, M.D.; Vincent P. Corso, M.D.; Victor Dabby, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Diane B. Eisman, M.D.; Richard M. Fleming, M.D.; Miguel Figueroa, M.D.; Marvin L. Jaffee, M.D.; George R. Gage, M.D.; L. Marshall Goldstein, M.D.; Norman Gottlieb, M.D.; Alan S. Graubert, M.D.; Maurice Greenfield, M.D.; Julian H. Groff, M.D.; Leo Grossman, M.D.; Joseph Harris, M.D.; Walter C. Jones III, M.D.; James R. Jude, M.D.; Norman M. Kenyon, M.D.; Warren Lindau, M.D.; Joseph T. Ostroski, M.D.; Milton S. Ross, M.D.; Oscar Sandoval, M.D.; Everett Shocket, M.D.; Samuel P. Stokley, M.D.; Chauncey M. Stone, M.D.; William M. Straight, M.D.; Charles F. Tate, M.D.; Edgar W. Webb, M.D.; Elliot Witkind, M.D.; Sheldon Zane, M.D.; (Absent — Leo Braverman, M.D.; John E. Cunio, M.D.; Eduardo E. Delgado, M.D.; Robert Elkins, M.D.; Franklin J. Evans, M.D.; Ivor Fix, M.D.; Eugene Flipse, M.D.; Richard L. Glatzer, M.D.; Pedro J. Greer, M.D.; Stephen H. Glucroft, M.D.; Max E. Gomez, M.D.; Marshall Hall, M.D.; Henry C. Hardin, M.D.; Robert B. Katims, M.D.; Banning G. Lary, M.D.; Maurice H. Laszlo, M.D.; Martin E. Liebling, M.D.; Ildefonso Rafael Mas, M.D.; Charles Monnin, M.D.; Raul Rivet, M.D.; Walter M. Sackett, M.D.; Edward St. Mary, M.D.; John Turner, M.D.; Shreve Archer, Student Delegate)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Warren M. Barrett, M.D.; William P. Booras, M.D.; Doris N. Carson, M.D.; Patricia C. Cowdery, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Emmet F. Ferguson Jr., M.D.; Clifford R. Guy, M.D.; Charles P. Hayes Jr., M.D.; John C. Kruse, M.D.; Charles W. Lewis, M.D.; Charles B. McIntosh, M.D.; Daniel B. Nunn, M.D.; B. Craig Ray Jr., M.D.; John A. Rush, M.D.; Guy T. Selander, M.D.; William D. Walklett, M.D.; (Absent — Yank D. Coble, M.D.)

ESCAMBIA — George L. Carr, M.D.; Eric F. Geiger, M.D.; Kenneth I. Holman, M.D.; Charles F. McConnell, M.D.; Henry M. Yonge, M.D.; Robert K. Wilson, M.D.

FRANKLIN-GULF — Joseph P. Hendrix, M.D.

HIGHLANDS — (Absent — Glenn V. Hough, M.D.; Robert T. Rengarts, M.D.)

HILLSBOROUGH — Richard A. Bagby, M.D.; Louis E. Cimino, M.D.; Francis C. Coleman, M.D.; Robert J. Courtney, M.D.; Irving Essrig, M.D.; John C. Fletcher, M.D.; Richard S. Hodes, M.D.; Donald W. Irvine, M.D.; Victor H. Knight Jr., M.D.; Joel W. Mattison, M.D.; Thomas E. McKell, M.D.; John K. Petrakis, M.D.; Ronald L. Seeley, M.D.; Ralph M. Stephan, M.D.; William W. Trice, M.D.; Harold L. Williamson, M.D.; Woody N. York, M.D.; Henry P. Freider, Student Delegate

INDIAN RIVER — (Absent — Donald L. Ames, M.D.; Ferdinand F. Becker, M.D.)

LAKE — Frederick C. Andrews, M.D.; James M. Hardy, M.D.; Thomas D. Weaver, M.D.

LEE — Larry P. Garrett, M.D.; John S. Hagen, M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr., M.D.; Marcus M. Moore, M.D.

MADISON — (Absent — William J. Bibb, M.D.)

MANATEE — Thomas R. Busard, M.D.; Sanford Elton, M.D.; John D. Lehman, M.D.; Roger A. Meyer, M.D.

MARION — C. Brooks Henderson, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; Richard Q. Penick, M.D.

MONROE — Ronald H. Chase, M.D.; (Absent — Robert P. Kaminsky, M.D.)

NASSAU — (Absent — Jose L. Castillo, M.D.)

OKALOOSA — David R. Arrowsmith, M.D.; Eugene R. Valentine, M.D.

ORANGE — Clarence H. Brown III, M.D.; Manuel J. Coto, M.D.; Sam F. Elder, M.D.; Clarence M. Gilbert, M.D.; Dorothy T. Lloyd, M.D.; Franklin B. McKechnie, M.D.; Hector R. Mendez, M.D.; Robert A. Metzger, M.D.; James F. Richards Jr., M.D.; James J. Schoeck, M.D.; Edward W. Stoner, M.D.; T. Byron Thames, M.D.; Robert B. Trumbo, M.D.; (Absent — Stephan A. Butler, M.D.; Donald V. Jablonski, M.D.; David L. Mackey, M.D.)

OSCEOLA — George A. Gant, M.D.
PALM BEACH — Vernon B. Astler, M.D.; John D. Corbitt Jr, M.D.; Louis F. Donaghue, M.D.; Lee A Fischer, M.D.; James Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; V. A. Marks, M.D.; Charles E. Metzger, M.D.; Benjamin Moore, M.D.; Robert D. Petersen, M.D.; Reginald J. Stambaugh, M.D.; Arthur L. Trask, M.D.; Dick L. Van Eldik, M.D.; (Absent — Thomas E. Murphy, M.D.)
PANHANDLE — Herbert E. Brooks, M.D.; William F. Brunner, M.D.
PASCO — Nessan McCann, M.D.; (Absent — Morris L. Saperstein, M.D.)
PINELLAS — Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Kay K. Hanley, M.D.; David S. Hubbell, M.D.; Morris J. LeVine, M.D.; Donald I. MacDonald, M.D.; Jack A. MaCris, M.D.; William F. Mallette, M.D.; Frank I. Mendelblatt, M.D.; James Hugh Miller, M.D.; James M. Neill, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Robert N. Price, M.D.; Frederick O. Smith, M.D.
POLK — Salvadore J. Barranco, M.D.; Thomas M. Caswall, M.D.; Clyde E. Gibson, M.D.; John W. Glotfelty, M.D.; Wiley E. Koon, M.D.; Stanley W. Lipinski, M.D.; Paul A. Tanner Jr., M.D.; (Absent — Frank J. Fischer, M.D.)
PUTNAM — Craig Raby, M.D.
ST. JOHNS — Constantine Antonatos, M.D.; Reuben J. Plant, M.D.
ST. LUCIE-OKEECHOBEE — William H. Meyer Jr., M.D.; Bruce E. Mills, M.D.
SANTA ROSA — (Absent — William N. Watson, M.D.)
SARASOTA — Wallace M. Bryant, M.D.; John N. Carlson, M.D.; Samuel E. Kaplan, M.D.; Kenneth C. Keihl, M.D.; Franklin Pfeiffenberger, M.D.; Karl R. Rolls, M.D.; (Absent — Richard E. Rehmeyer, M.D.)
SEMINOLE — Luis M. Perez, M.D.; Frederick J. Weigand, M.D.
SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Laurent V. Radkins, M.D.)
TAYLOR — John H. Parker, M.D.
VOLUSIA — Richard L. Dillard, M.D.; Frank J. Lill, M.D.; Alvin E. Smith, M.D.; Charles A. Stump, M.D.; James G. White, M.D.; (Absent — Irwin Leider, M.D.)
WALTON — (Absent — Thomas G. Spence, M.D.)
SPEAKER OF THE HOUSE — Charles J. Kahn, M.D.
VICE SPEAKER — Sanford A. Mullen, M.D.

Installation of the President

Dr. Kahn recognized the President, Dr. Louis C. Murray. Dr. Murray stated that it had been a great honor and pleasure to serve the House and the membership at large this past year. Dr. Murray pointed out that the Association operates on the committee system which works well and is strong. He stated that he had confidence for the future of the FMA as he turned the office over to Dr. Davenport, an able and strong leader.

Dr. Murray presented the personal gavel and President's certificate to Dr. Davenport, the new President.

Dr. Davenport presented Dr. Murray with the Past President's pin and thanked him for all the instructions and counsel given during the past year.

Dr. Davenport asked Dr. Thames and Dr. Stoner to escort Mrs. Murray to the podium, where he presented her with Dr. Murray's portrait.

Dr. Murray introduced his children: Louis Jr., John, Joellyn, Mary Rose and Stephen.

Dr. Davenport deferred any presidential remarks so that the House might continue with the regular order of business.

The Speaker resumed the Chair and called for the report of Reference Committee No. III.





Retiring President Louis C. Murray, M.D. (right in left picture) presents his successor, O. William Davenport, M.D, with his President's Certificate. In right photo, Dr. Davenport affixes the Past President's Pin on Dr. Murray's lapel.

Report of Reference Committee No. III
Finance and Administration

The Reference Committee recognized Dr. Luis M. Perez as the recipient of the 1977 Benjamin Rush Award for community service by a physician. This prestigious award had been presented to Dr. Perez at the Interim Meeting of the AMA House of Delegates in December.

The Reference Committee noted that portion of the Board of Governors report referring to nominations for recipients of the Certificate of Merit and Certificate of Appreciation. It was pointed out that the House had already approved the nomination for the Certificate of Merit and that all had observed the impressive presentation ceremonies earlier.

The motion of the Reference Committee that the Board of Governors' nominations of Charles H. Carter, M.D., and E. Charlton Prather, M.D., to receive the 1978 FMA Certificates of Appreciation be adopted carried.

The Speaker requested Dr. Thames to escort Dr. Carter, and Dr. Peek to escort Dr. Prather to the podium to receive their awards.

Certificate of Appreciation

Charles H. Carter, M.D.

Whereas, Charles H. Carter, M.D., of Orlando, Florida, has rendered distinguished and able service to the medical profession and citizenry of the state of Florida since 1951; and

Whereas, This dedicated physician received his medical degree from the University of Tennessee, and remained at the University for his internship and residency; and

Whereas, This able physician served as instructor in Pediatrics at University of Tennessee, St. Joseph's Hospital; and

Whereas, Dr. Carter has been a member of the Florida Medical Association and the Orange County Medical Society; and

Whereas, This eminent gentleman served as Director of Orlando's Sunland Hospital for 17 years, and was subsequently honored for his service in the care, habilitation and rehabilitation of retarded persons by the Florida House of Representatives in 1976; and

Whereas, Dr. Carter is recognized as an authority in retardation and genetics and has authored or co-authored more than 100 articles on the subjects since 1954; and

Whereas, Dr. Carter holds a Fellowship Degree in the American Academy of Family Physicians; and

Whereas, Dr. Carter has served the people of the State of Florida and the medical profession; therefore be it

RESOLVED, That a Certificate of Appreciation be presented to Charles H. Carter, M.D., as a token of the warm appreciation that the officers, members and executive staff of the Association hold for the many years of outstanding service rendered by this fine gentleman.

Certificate of Appreciation

E. Charlton Prather, M.D.

Whereas, Elbert Charlton Prather, M.D., of Tallahassee, Florida, has rendered distinguished and able service to the medical profession and citizenry of Florida since 1961; and

Whereas, This dedicated physician was born in Jasper, Florida, on March 13, 1930; attended the University of Florida and was graduated from Bowman Gray Medical School with an M.D. degree; and

Whereas, This able physician is an active member of the Capital County Medical Society, the Florida Medical Association, the Florida



Reference Committee III considered reports and resolutions in the area of finance and administration. Left to right: Brian P. Gibbons, M.D., Cocoa Beach; Franklin Pfeiffenberger, M.D., Sarasota; Ms. Jan Taylor, Jacksonville, Recording Secretary; Chauncey M. Stone, M.D., Miami, Chairman; John H. Parker, M.D., Perry; Eugene Valentine, M.D., Fort Walton Beach; and Samuel M. Day, M.D., Jacksonville, AMA Delegate Advisor.

Society for Preventive Medicine, American Public Health Association, Florida Public Health Association, American Society for Epidemiologic Research, Conference of State and Territorial Epidemiologists, the Florida Chapter, American College of Chest Physicians, and the American Medical Association; and

Whereas, This eminent gentleman has spent his entire professional career with or under the auspices of the Florida Public Health Program; and

Whereas, Dr. Prather has served as Clinical Professor of Infectious Disease at the University of Miami School of Medicine, and at University Hospital of Jacksonville through the University of Florida, and has served as project director for more than a dozen special research, specially funded projects to the State Health Program; and

Whereas, Dr. Prather is currently serving as Staff Director of the Health Program Office, Florida Department of Health and Rehabilitative Services; therefore be it

RESOLVED, That a Certificate of Appreciation be presented to Elbert Charlton Prather, M.D., as a token of the warm appreciation that the officers, members and executive staff of the Association hold for the many years of outstanding service rendered by this fine gentleman.

The motion of the Reference Committee to amend the Board's report on Hospital Staff Privileges, by adding the sentence "A Section of Podiatry can be created and podiatrists granted staff privileges within their lawful scope of practice" after "and to certain dentists who meet the criteria of the medical staff bylaws" was discussed.

An amendment to the Reference Committee motion was made but failed to carry.

A substitute motion to refer hospital staff privileges to the Board of Governors was made but failed to carry.

A motion was made to amend the Reference Committee motion by striking the word "staff" before the word "privileges."

A motion to change the word "can" to "may" carried, and the amendment deleting the word "staff" carried.

The motion of the Reference Committee as amended carried.

Recommendation No. 20 regarding advertising has been rendered moot by the recent action of the SBME in adopting rules and regulations that comply with the philosophy and intent of Recommendation No. 20.

The motion of the Reference Committee that the Board's report concerning advertising and Recommendation No. 20 not be adopted carried.

Resolution 78-10
FMA Bylaws Change — Called Meetings
Palm Beach County Medical Society

Since the Board's Recommendations concerning By-laws changes for called meetings of the House and Resolution 78-10 dealth with the same subject, they were considered together.

The motion of the Reference Committee that the Recommendation for By-laws amendments concerning called meetings of the House be adopted as written carried.

The motion of the Reference Committee that Resolution 78-10 not be adopted carried.

The motion of the Reference Committee that the report of the Board of Governors be adopted as amended, with the exception of those items referred to other Reference Committees, carried.

Report of Board of Governors
Louis C. Murray, M.D., Chairman

Your Board of Governors is pleased to submit the following report to the House of Delegates regarding its activities during the past Association year. The Board has held five meetings: May 8, 1977; June 26, 1977; October 6-7, 1977; January 14, 1978; and March 11, 1978.

The report will reflect the continuing efforts of FMA through its many programs to insure the highest quality medical care for the citizens of Florida, regardless of ability to pay or geographic location, and preservation of the highest standards and ethics for our profession. This report also reflects the efforts of the Association in seeking realistic and workable solutions to the problems of increasing health care costs.

The report reflects the continued fight against the incessant arbitrary and unwarranted intrusion into the practice of medicine, manifest in such government programs as PL 93-641, Certificate of Need, rate review, release of physicians' fees, which threaten the endurance of our profession.



E. Charlton Prather, M.D., Staff Director of the Florida Health Program Office, received an FMA Certificate of Appreciation. With him is House Speaker Charles J. Kahn, M.D.

Your Board is grateful to the many physicians who have served on FMA Councils and Committees and to those who have represented the FMA at countless meetings at the local, state and national level.

Your Chairman is honored for the opportunity of serving the FMA during this past year. It has been a particular privilege to associate with those physicians who have served on the Board. To a man, they have given freely of their time and talents in representing the best interest of their fellow physicians: Vernon B. Astler, M.D.; O. William Davenport, M.D.; J. Lee Dockery, M.D.; Richard S. Hodes, M.D.; Norman Kenyon, M.D.: Jack A. MaCris, M.D.; Theodore J. Marshall, M.D.; Donald G. Nikolaus, M.D.; Edward Stoner, M.D.; Robert E. Windom, M.D.; Benjamin M. Cole, M.D.; Charles J. Kahn, M.D.; Joseph G. Matthews, M.D.; and Eugene G. Peek Jr., M.D.

I wish my successor, Dr. O. William Davenport, the same rewarding experiences I have enjoyed as he assumes leadership of such a fine organization.

Major Activities

Your Board has spent many hours in formal session in review of the activities of councils and committees and many other crucial matters of primary concern to medicine. The following is a summary of the major activities and actions of the Board in its deliberations and its recommendations to the House of Delegates.

1978 Annual Meeting — The Board approved the format for the 1978 Annual Meeting and noted with pleasure the continuing improvement in the quality of the scientific program and the promptness with which the program is prepared. Dr. Henry Yonge and Dr. Maurice Laszlo (and the members of the Subcommittee on Annual Meeting Scientific Program) were commended for their efforts in this regard.

1978 Called Meeting of the House of Delegates — No Interim Meeting of the House of Delegates or Leadership Conference was held during this past Association year. The Board requested that the President schedule a Called Meeting of the House of Delegates, February 4-5, 1978, to consider the Association's state and national legislative program and that the format include a president's report on the Association's priorities. This meeting was cancelled due to a lack of a quorum of delegates.

The Board authorized a President's Conference, to be held on February 4, 1978, provided there was adequate interest shown by the county medical society presidents to meet with the officers of the FMA. There was not sufficient interest shown to hold such a conference.

Included in the Board's report and in other Council and Committee reports in the Delegate's Handbook are reports and recommendations regarding the Association's legislative programs, and other program priorities.

Financial Statement and Budget — The Board reviewed the financial report prepared by the Executive Vice President and approved the auditors' statement presented by the Treasurer prepared by Lucas, Herndon, Hyers & Pennywitt. These reports covered the calendar year 1977 and showed the Association's regular income from all sources was $1,495,020, and total expenses during the year were $1,456,197 for a net income of $38,823. These figures do not include funds expended for equipment or depreciable items as these are a transfer of assets from liquid to fixed. Funds received from the Special Assessment for Public Relations and Legislation in 1976 and 1977 totaled $876,100 and as of December 31, 1977, had a balance of $221,744. The total assets of the Association as of December 31, 1977, was $2,331,610, less liabilities of $677,640 for net assets of $1,653,970.

The House of Delegates increased the dues of the Association effective January 1, 1978, for active members from $125 to $175 per year and designated $50 ". . . to be earmarked for public relations and legislative educational activities." The Board approved a budget for 1978 totaling $1,969,000, which is the total anticipated income from all sources. In compliance with the Bylaws, this budget was prepared by the Executive Vice President in consultation with the Treasurer. It was then carefully reviewed by the Executive Committee which also serves as the Finance Committee, and finally reviewed and approved by the Board of Governors.

House of Delegates Referrals

The 1977 Proceedings of the House of Delegates were reviewed and items requiring additional study and action were referred to the appropriate Councils and Committees. Some matters required Board action only. Individual actions regarding the policies of the House of Delegates appear in the various Council and Committee reports as well as in this report.

Pap Smears — The House of Delegates referred the recommendation on pap smears to the Board of Governors for further study.

Recognition of pap smears as a necessary procedure has been recommended on a recurring basis and frequent requests have been made for reimbursement to physicians for this procedure by all government medical care programs and third parties.

RECOMMENDATION NO. 1

THAT THE FMA SUPPORT THE CONCEPT OF A HOSPITAL BASED UTERINE CYTOLOGY PROGRAM TO BE ON A VOLUNTARY BASIS AS DEEMED APPROPRIATE BY EACH HOSPITAL MEDICAL STAFF. (Adopted — R.C. I)

Resolution 77-8, High School Sports — This resolution introduced by the Brevard County Medical Society was not adopted but referred to the Board of Governors for consideration and appropriate action.

The resolve of this resolution provided that FMA recommend to the Florida High School Activities Association that spring sports commence later in the season and that spring football practice be discontinued.

At its Fall Meeting the Board reviewed a report and recommendation from the Committee on Sports Medicine regarding this subject.

It was the Committee's recommendation that the FMA only address the medical aspects of high school sports and should not get involved with the scheduling of high school activities; further, the FMA should recommend to the Florida High School Activities Association that football coaches should devote more time in spring football practice to conditioning before initiating physical contact work and under no circumstances should spring football practice interfere with a student's participation in other spring sports. This subject will be discussed with the Florida High School Activities Association and a report made to the Board of Governors. **(Adopted — R.C. II)**

Resolution 77-5, Health Systems Agencies — This resolution which was introduced by the Capital Medical Society was not adopted but referred to the Board of Governors for consideration. The resolve of this resolution recommended that FMA assist in any possible way to test the constitutionality of the Health Systems Agency and Public Law 93-641.

This resolution was reviewed by FMA and AMA legal counsel. The Board of Governors in July requested an opinion from AMA legal counsel as to the feasibility of FMA contesting implementation of PL 93-641 in Florida. It was pointed out that the State of North Carolina, the AMA, the North Carolina Medical Society and the State of Nebraska had filed a suit contesting the constitutionality and validity of PL 93-641. A three judge panel in the Federal District Court in the

Eastern District of North Carolina denied the petition and the decision is now being appealed to the U.S. Supreme Court. It was the opinion of AMA legal counsel that legal action by the FMA would not be feasible at the present time pending the results of the North Carolina suit. This was concurred in by FMA legal counsel.

The Board of Governors has also requested the FMA Committee on HSA's to study other aspects of HSA's and report back to the Board with its findings and recommendations.

As indicated in the Council on Legislation's report to the House of Delegates, major effort will be directed toward amending PL 93-641 to remove the law's adverse provision and to make the law more workable.

RECOMMENDATION NO. 2

THAT FMA SUPPORT AMENDMENTS TO PL 93-641 THAT EXPRESS THE FOLLOWING:

1. ANY NATIONAL GUIDELINES FOR HEALTH PLANNING BE STRICTLY ADVISORY.
2. THE BASIC PRINCIPLE OF HEALTH PLANNING SHOULD BE DETERMINED AT THE LOCAL LEVEL AND NOT MANDATED BY FEDERAL OR STATE GOVERNMENT.
3. THE CLASSIFICATION OF "INDIRECT PROVIDER" SHOULD BE ELIMINATED THUS ALLOWING MORE POSITION ON THE STATE HEALTH COORDINATING COUNCIL AND HSA GOVERNING BODIES FOR ACTUAL HEALTH CARE PROVIDERS.
4. INSTEAD OF DECERTIFYING DUPLICATIVE OR UNNEEDED HEALTH SERVICES OR FACILITIES, SUCH SERVICES OR FACILITIES SHOULD BE CONVERTED TO MEET OTHER HEALTH NEEDS.
5. "CERTIFICATE OF NEED" SHOULD NOT BE A PART OF THE NATIONAL HEALTH PLANNING AND RESOURCE DEVELOPMENT ACT OF 1974.
6. DOCTORS' OFFICES SHOULD NOT BE SUBJECT TO "CERTIFICATE OF NEED."
7. VA FACILITIES AND HMO'S SHOULD BE COVERED UNDER THE ACT INSTEAD OF RECEIVING SPECIAL PRIVILEGES.
8. THE GOVERNOR OF A STATE SHOULD HAVE THE FINAL SIGN OFF ON THE STATE HEALTH PLAN.
9. THE STATE HEALTH PLAN SHOULD BE CONSISTENT WITH STATE LAW.
10. THE AUTHORITY OF THE SECRETARY OF HEW TO ESTABLISH A UNIFORM SYSTEM FOR RATE CALCULATION, AND A SYSTEM FOR CLASSIFICATION OF HEALTH SERVICES INSTITUTIONS SHOULD BE ELIMINATED.
11. TRAINING PROGRAMS FOR STATE HEALTH COORDINATING COUNCIL MEMBERS AND HSA GOVERNING BODY MEMBERS SHOULD REPRESENT THE THINKING OF PROVIDERS AS WELL AS PLANNERS.
12. THE ACTIVITIES OF THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCY (SHPDA) SHOULD BE COORDINATED THROUGH THE STATE HEALTH COORDINATING COUNCIL (SHCC).
13. THE FINAL DECISION ON CERTIFICATE OF NEED SHOULD REST WITH THE SHCC AS OPPOSED TO HEW.
14. TO INSURE THE QUALITY OF MEDICAL CARE TO CONTINUE IN THE UNITED STATES THAT PL 93-641 BE REPEALED. (Adopted — R.C. V)

Resolution 77-16, Waiver of Coverage — This resolution introduced by the Alachua County Medical Society was not adopted but referred to the Board of Governors to monitor the activities of a Blue Cross/Blue Shield task force which has been established to review all contracts, giving particular attention to waivers and riders, and requested that the Board make a progress report to the House of Delegates at the 1978 Annual Meeting. The resolve of this resolution called for Blue Shield and Blue Cross to:

> Cease the present administrative practice of requiring total waiver and institute a practice of requiring waiver of only those problems related directly to the condition in question and not the total system; further
>
> That Florida Blue Shield and Blue Cross revise the waiver provisions of current individual contracts to provide that the waiver of coverage applies only to pre-existing problems and those problems related directly to the condition in question and not the total system; further
>
> That the officers, Board of Governors, Committees, members and employees of the Florida Medical Association be directed to use their offices to implement this Resolution through Florida Blue Shield and Blue Cross.

At its Fall Meeting the Board reviewed correspondence from Dr. Joe Matthews, Chairman, Blue Shield, advising that Blue Shield was taking steps to rectify discrepancies in its policy regarding waiver of coverage where warranted. The Board directed that this information be transmitted to the House of Delegates. **(Adopted — R.C. V)**

Resolution 77-25, Medicare Physicians' Profiles — (Filed — R.C. V)

Resolution 77-18, Relationship Between FMA and Component Medical Societies — This resolution introduced by the Monroe County Medical Society was not adopted but referred to the Board of Governors for investigation and recommendation. The resolve of this resolution recommends:

> That the House of Delegates of the Florida Medical Association reaffirm the principles as set forth in the Charter and Bylaws of the Association that matters of complaint, investigation, peer review and discipline be the initial responsibility of the component societies; further
>
> That the Association and/or its Councils and Committees not take action in matters of complaint and



Mrs. Louis C. Murray of Orlando, wife of the retiring FMA President, proudly displays his portrait as Dr. Murray and his successor, Dr. O. William Davenport, M.D., of Miami, look on.

investigation regarding its members without initial consultation with or the advice of his or her society's officers or representatives.

The Committee on County Medical Society Presidents has reviewed the substance of the resolution and submitted its report and recommendation.

RECOMMENDATION NO. 3

THAT IN REGARD TO COMPLAINTS FILED AGAINST MEMBERS OF THE MONROE COUNTY MEDICAL SOCIETY, IT IS THE OPINION OF THE COMMITTEE THAT THE FLORIDA MEDICAL ASSOCIATION JUDICIAL COUNCIL CONDUCTED THE INVESTIGATION IN ACCORDANCE WITH THE FLORIDA MEDICAL ASSOCIATION BY-LAWS AND FOLLOWED APPROPRIATE PROCEDURES; THEREFORE, IT IS RECOMMENDED THAT RESOLUTION 77-18 NOT BE ADOPTED.

Board Actions of Major Importance

The Board adopted the following Association priorities for 1977-78 and directed that all the Association staff and resources be utilized in carrying out these priorities. As provided in the Bylaws, $50.00 per member for all FMA active dues paying members has been designated for public relations and legislative educational activities.

MEMBERSHIP:

—Continue and intensify the informational program for county medical societies and the membership.

—Continue and strengthen all aspects of Continuing Medical Education Program and accelerate accreditation activities.

—Improve liaison and coordination with county medical society officers and staffs, and specialty groups.

PUBLIC:

—Continue to implement the FMA Medical Services Program with special emphasis on emergency medical services.

—Careful analysis and implementation of a program dealing with the cost of medical care to include continued study and implementation of programs to assist in containing the rapid increase in the cost of medical care including evaluation and appropriate enactment of proposed cost containment legislation.

PROGRAMS:

—Further implementation of FMA Public Relations program for members and the general public.

—Place more emphasis on depth and grass roots support for legislative activities.

—Implement a political educational program and an active committee in each community.

—Careful study and liaison with the Florida Constitution Revision Commission.

Health Planning Activities — As reported in another section of this report, special priority has been given to PL 93-641, National Health Planning and Development Act — specifically, HSA activity in the State of Florida. The FMA is totally committed to an appropriate level of physicians' input into health planning and also to bringing about legislation which would remove the deleterious provisions of this law. **(Adopted — R.C. V)**

Health Data System — The Association has been successful in creation of the Florida Health Data Corporation. The purpose of this corporation — whose membership is composed of representatives of the FMA, the Florida Hospital Association and the Florida Osteopathic Medical Association — is to establish a mechanism for health data collection in the private sector. It is part of FMA's effort to establish a statewide peer review organization (PRO).

Through a contract with Medical Dimensions, Inc., of Houston, Texas, the FHDC has created a hospital medical management information system (HMMIS) and a pilot program for data collection is currently being conducted. Twelve Florida hospitals, seven of which are public and five not-for-profit organizations, are participating in the pilot program.

It is anticipated that the FHDC will meet the requirements of HSA's and PSRO's for providing accurate and timely medical data with protection of confidentiality, and insuring qualified health planning and utilization review activities. **(Adopted — R.C. V)**

Separate Department of Health — Restoration of a viable Department of Health in the State of Florida has been at the forefront of the Association's priorities. FMA President, Dr. Murray, appeared before the Constitution Revision Commission as did other FMA representatives, to present testimony in support of a constitutional Department of Health. Dr. Edward Annis, a member of the Commission, has been largely responsible for the Commission's overwhelming support for inclusion of a separate Department of Health in Florida's Constitution. His articulate and factual presentations on Florida's past performance as a leader in public health programs and services measured against the continuing deterioration in health services brought about by government reorganization was convincing testimony to reestablish a separate Department of Health and a great victory for the citizens of Florida.

Implementing legislation for a separate Department of Health is a top priority in the Association's 1978 legislative program. **(Adopted — R.C. IV)**

Recovery of Defense Cost — The FMA will continue its efforts to bring about enactment of legislation to provide for recovery of defense cost in unwarranted law suits. This also is a top priority of the FMA 1978 legislative program.

These and other matters of concern to organized medicine to be considered by the 1978 Florida Legislature are included in the Delegate's Handbook. **(Adopted — R.C. IV)**

Medicaid — The FMA has long been an advocate for improvements in Florida's Medicaid Program and a recommended policy statement on health care for the indigent is included in the Delegate's Handbook. In addition, FMA has on numerous occasions offered recommendations to the Department of HRS for improving the Medicaid Program, including increased physician participation. The Association has also offered to provide peer medical utilization review for physicians' services. In November 1977, a contract was executed between the Florida Medical Foundation and the Department of HRS whereby the FMF agrees to provide peer medical utilization review services for Medicaid. **(Adopted — R.C. V)**

House of Delegates Ratios — The Board approved the current ratio of one delegate to each forty active members used in determining the total composition of the House of Delegates for the 1978 Annual Meeting. (No change this year)

Pre-Trial Medical Mediation Panel Procedures — The Board approved the petition to the Florida Supreme Court to amend the proposed rules of the Florida medical mediation procedures on behalf of the FMA as prepared by FMA legal counsel.

Emergency Medical Services — FMA representatives were authorized to pursue negotiating a federal contract to perform emergency medical services in Florida, which are currently being performed by the State of Florida, through the Florida Medical Foundation. **(Adopted — R.C. II)**

FMA Defense Fund — Received as information an updated report on FMA assistance to physicians for countersuits (currently 10 in number) and, in particular, the successful suit of John B. Sullivan, M.D., who was awarded $175,000 and settled for the reduced amount of $75,000 as set by the trial judge, and Sidney H. Burness, M.D., who was awarded $15,000 in damages.

1977 Legislative Session — Reviewed in detail the FMA Legislative Program during the 1977 Session of the Florida Legislature and commended those individuals directly concerned with its success.

Headquarters Building and Branch Offices — The Board of Governors approved purchase of the Commercial Union building located approximately ½ block from the FMA headquarters office on Riverside Avenue.

The two-story red brick structure contains 30,000 square feet. FMA is housed on the second floor with PIMCO leasing part of the first floor. Being housed under the same roof has enabled the two organizations to function more efficiently and to share many of the costs and equipment formerly incurred individually. There is ample space for future growth by both organizations. It is expected that the payment of the $990,000,purchase price will be made largely through sale of the FMA headquarters building and the May Street property. Any remaining mortgage will be paid from income received from lease of office space to PIMCO.

The FMA Capital Office purchased in 1975 was renovated and occupied by the Capital Office staff in early June 1976. The single story building contains approximately 3,000 square feet of office space and is strategically located just one block from the Capitol. This $120,000 expenditure was paid for by FMA's interest in Harlan-Med, Inc.'s liquidation distribution and not from Association reserves.

In addition to moving to the new headquarters, FMA has opened two new regional offices — one in Miami to serve south Florida, and another in Tampa, to serve central Florida. These two offices are in addition to the Capital Office in Tallahassee, which has been in operation since 1969.

The purpose of these two additional offices is service to the news media, legislators, county medical societies, and physicians in the state. Florida's growing population and the increasing complexity of medical activities indicated a need for expanded service by the FMA.

The FMA South Florida Office opened officially November 1, 1977. It is housed in the Central Bank Building, 18350 NW 2nd Avenue, Miami, with Mr. Eugene J. Johnson as manager. A native of Minnesota and formerly associated with the Dade County Medical Association, Mr. Johnson will be responsible for implementing the programs and policies of the FMA, as well as assisting the county medical societies and physicians, in the south Florida area.

The Central Florida Office, located in the Tampa Host International Hotel at Tampa Airport, is managed by Mr. Russell E. Berge. Mr. Berge is a native of North Dakota and formerly served as Administrative Assistant to members of the Florida House and Senate.

The Capital Office in Tallahassee will serve as the North Florida regional office, thus placing FMA offices in all major areas of the state. Mr. George S. Palmer Jr. will continue as manager of the Capital Office in Tallahassee, and is responsible for field work in North Florida in addition to his duties as Executive Director of FLAMPAC. The Legislative Affairs Department, headed by Mr. Donald S. Fraser Jr., will continue to be housed in the Capital Office.

The purpose and function of these branch offices is to develop an in-depth, integrated program for legislative education and activities, public relations, and political education. These offices and their staffs are intended to assist in coordination of the activities of county medical societies and not in any way interfere with or replace current programs and activities.

Appointments — The Board of Governors approved the nomination of Joseph C. Von Thron, M.D., as the AMA Delegate to serve on the Board of Governors. Thomas B. Thames, M.D., Orlando, was appointed as optional member of the Executive Committee.

Appointed as advisory members of the Board of Governors were Eugene G. Peek Jr., M.D., Department of Health and Rehabilitative Services; Joseph G. Matthews, M.D., Blue Shield of Florida, Inc.; Benjamin M. Cole, M.D., Florida State Board of Medical Examiners; and Charles J. Kahn, M.D., Speaker of the House of Delegates. Vernon B. Astler, M.D., was designated as Public Relations Officer and Joseph C. Von Thron, M.D., was designated as the Board's representative to FLAMPAC.

Gerold L. Schiebler, M.D., was reappointed to serve as Editor of the *Journal of the Florida Medical Association* for 1978-79. William M. Straight, M.D., was appointed FMA Historian and Historical Editor of the *Journal*, and Edward W. Stoner, M.D., was designated as the Board of Governors' representative on the Committee on Scientific Publications.

Appointed as chairmen of standing committees of the Board were: *Committee on Allied Health Professions:* Luis M. Perez, M.D. *Committee on Voluntary Health Agencies:* Robert C. Palmer Jr, M.D. *Committee on County Medical Society Presidents:* Donald G. Nikolaus, M.D.

Appointed as chairmen of special committees were; *Committee on Health Systems Agencies:* Charles F. Tate, M.D. *Committee on Cost of Medical Care:* James F. Richards Jr., M.D. *Ad Hoc Committee on Nutrition:* Yank D. Coble Jr., M.D.

James T. Cook, M.D., and Burns A. Dobbins Jr., M.D., were elected Chairman and Vice-Chairman respectively of the FMA Delegates to the American Medical Association.

American Cancer Society Resolution on Smoking — The Board received a request from the American Cancer Society, Florida Division, for support of a resolution regarding the health hazards of smoking.

RECOMMENDATION NO. 4

THAT FMA SUPPORT THE FLORIDA DIVISION, AMERICAN CANCER SOCIETY'S RESOLUTION ON SMOKING WHICH ENCOURAGES PHYSICIANS TO SERVE AS EXAMPLES BY ELIMINATING CIGARETTE SMOKING:

Whereas, Statistics for the ten-year period following the release of the report by the Surgeon General of the United States Public Health Service in 1964, indicate the total number of deaths in this country from just two diseases (lung cancer and emphysema) amounted to more than three-quarters of a million people; and

Whereas, Cigarette smoking is the single most preventable cause of lung cancer and emphysema, and that the evidence linking cigarette smoking to disease and death is now overwhelming; and

Whereas, Cigarette smoking is again on the increase, particularly among teenage girls and young women; and

Whereas, We, as physicians, have a public responsibility to serve as exemplars and educators: therefore be it

RESOLVED, That we, as exemplars, eliminate cigarette smoking as a personal habit; and therefore be it further

RESOLVED, That we acknowledge the role of cigarette smoking as a public health problem affecting the smoker, the non-smoker and the young; and be it further

RESOLVED, That we use our influence to eliminate cigarette smoking from all medical and health-related facilities, i.e., hospitals, clinics, private offices, medical schools, medical meeting places, etc.; and be it further

RESOLVED, That we will actively promote smoking cessation among our patients by demonstrating our concern for their well-being and reinforcing their efforts to stop cigarette smoking by counseling, by provision of educational materials, by eliminating smoking from all medical facilities, by instructing all personnel to refrain from smoking and by serving as exemplars; and be it further

RESOLVED, That we use our influence to enact anti-

smoking legislation within our local communities; and be it further

RESOLVED, That we will use our influence with other health-related professionals to gain their cooperation in anti-smoking efforts. (Adopted — R.C. I)

AMA President-Elect — The Board expressed enthusiastic support for the nomination of Jere W. Annis, M.D., Lakeland, Florida, for the office of President-Elect of the AMA at the Annual Meeting in St. Louis. As indicated in the annual report of the AMA Delegates, the entire Florida delegation is working to bring about Dr. Annis' election. All FMA members are urged to lend their support.

AMA Benjamin Rush Award — Nominated Dr. Luis M. Perez, Sanford, Florida, to the AMA for consideration as recipient of the 1977 Benjamin Rush Award for community service by a physician.

Dr. Perez was subsequently selected as recipient of this prestigious award which was presented to him at the Interim Meeting of the AMA House of Delegates in December.

Definition of Public Health — The Board had been asked for an opinion as to what constitutes a viable definition of public health:

RECOMMENDATION NO. 5

THAT THE FMA ADOPT THE FOLLOWING DEFINITION OF PUBLIC HEALTH:

"PUBLIC HEALTH IS A SCIENCE AND ART OF APPLYING KNOWLEDGE AND SKILLS FROM MEDICAL AND ALLIED SCIENCES IN AN ORGANIZED COMMUNITY EFFORT TO MAINTAIN AND IMPROVE THE HEALTH OF THE TOTAL COMMUNITY." (Amended — R.C. II)

Conference on Gerontology — The Board approved FMA cosponsorship of the 27th Annual Southern Conference on Gerontology on March 28-31, 1978, in Gainesville. The theme of the Conference is "Back to Basics" and will involve the issues of nutrition and shelter for the elderly. (Adopted — R.C. II)

Florida Psychiatric Society Resolution — The Board received a resolution adopted by the Florida Psychiatric Society regarding the state's mental health hospital programs.

RECOMMENDATION NO. 6

THAT THE FMA SUPPORT THE RESOLUTION ADOPTED BY THE FLORIDA PSYCHIATRIC SOCIETY REGARDING THE STATE MENTAL HEALTH HOSPITALS.

Whereas, The Florida Psychiatric Society has noted with alarm the actions of the Florida Department of Health and Rehabilitative Services in establishing a new, untried and unwise system of supervision and management in the state hospitals, and

Whereas, Utilization of personnel other than trained psychiatrists as unit directors of large groups of hospitalized patients is a step backward in patient care, and, a planned promotion of unqualified personnel to jobs of supervision of such units of 300 to 400 patients is not in keeping with our Florida Psychiatric Society's drive for improved care of hospitalized patients, and

Whereas, The Department's pragmatic downgrading of psychiatrists in the administrative hierarchy reflects unfortunately the too generalized lack of appreciation on the part of many socially committed agents for the necessity of trained medical personnel accepting the responsibility for patient care, and, that there is a fallacious concept of mental illness being a partial result of inadequate training and the idea that, for instance, behavior modifying procedures will suffice reflect this misunderstanding by many, mostly non-physicians, who lack proper appreciation of the extent and severity of mental illness and the medical model, and

Whereas, Florida has lagged behind other southeastern states in the financial support of state hospitals and provides one of the lowest per diem allowances per patient day of treatment, and to regress further in the care of our mentally ill is a continuing erosion of our commitment to the needs of patients and their families and a continuing denial of the need for trained psychiatrists to supervise and guide treatments rendered, and

Whereas, The Florida Psychiatric Society appreciates the problem hospital authorities have in acquiring adequate competent physicians, it nonetheless does not believe that the mentally ill should be the victims of less than high level professional care since with adequate appropriations and salaries staff could be obtained, and therefore be it

RESOLVED, That the Florida Psychiatric Society solicits the support of the Florida Medical Association in making known to the people of Florida, including the Governor of Florida and the members of the State Legislature the gross unsuitability of the management and supervisory changes planned by the Department of Health and Rehabilitative Services, and be it further

RESOLVED, That the Florida Psychiatric Society, through the Florida Medical Association, requests the Department of HRS be required to obtain necessary medically trained personnel to direct and supervise the state mental hospital programs and elevate the care of the state's mentally ill to an acceptable level of care. (Adopted — R.C. II)

Health Care in Correctional Institutions — The Board requested the AMA to consider Florida as a pilot state for the purpose of consideration being given by the AMA Council on Standards for the Accreditation of Medical Care and Health Services in Jails.

This action came about as a result of a request for support by the Duval County Sheriff's Department that had applied for a grant. (Adopted — R.C. II)

Medical School Deans — Excellent rapport has been maintained with Florida's three medical schools. The three deans participated in the fall meeting of the Board of Governors and each presented a timely report on the activities of each school.

The Board was saddened by the death of Dr. Chandler A. (Al) Stetson, Dean of the University of Florida College of Medicine. Dr. Stetson was a highly respected physician and had been a true friend of organized medicine.

Awards

A. H. Robins Award — The Board reviewed nominations received from county medical societies and selected the recipient of the A. H. Robins Company Award "For Outstanding Community Service by a Physician." This award will be presented at the First Meeting of the House of Delegates on May 3, 1978. The recipient for this year's award is included in the Delegates' Packets.

Distinguished Layman's Award — The Board has selected the 1978 recipient of the Distinguished Layman's Award. The appropriate citation, along with criteria, is included in the Delegates' Packets for information.

Nominations

Certificate of Merit & Certificate of Appreciation — The Board selected an outstanding physician for nomination to the House



The Editor's Dinner

1, Gerold L. Schiebler, M.D., Editor of *The Journal* introduces Assistant Editor Edward W. Stoner at the Annual Editor's Dinner, which was held in conjunction with the Annual Meeting. 2, Historical Editor William M. Straight, M.D., (left) chats with Mrs. Edward W. St. Mary and Dr. St. Mary, an Assistant Editor. 3, Enjoying the evening are Dr. and Mrs. Yank D. Coble Jr. 4, *The Journal*'s first student editors: Mr. (now Dr.) Alan Zablocki of the University of South Florida; Mr. Richard Snyder of the University of Miami; and Mr. Jerrold A. Van Dyke of the University of Florida. Among others attending were Associate Editor Clyde M. Collins, M.D. (5), Assistant Editor A. Lee Messer, M.D. (6), and Associate Editor E. Charlton Prather, M.D. (7).

of Delegates to receive the Certificate of Merit for 1978 (the Association's highest honor of achievement). The Board has also nominated two physicians to receive the 1978 Certificate of Appreciation. These nominations are included in the Delegates' Packets for approval by the House of Delegates.

Judicial Council — In compliance with the FMA Bylaws, the Board of Governors has considered nominations for terms expiring on the Judicial Council in 1978. The Board nominated Robert J. Brennan, M.D., to the House of Delegates for election to the Judicial Council as the representative from District C for a five-year term.

Committee on Membership and Discipline — In compliance with the Bylaws, the Board has reviewed terms expiring in 1978 on the Committee on Membership and Discipline. Nominations from county medical societies have been considered and the Board nominates the following physicians for election to the Committee on Membership and Discipline for the terms indicated:

District 1	Lealis L. Hale Jr., M.D., (82)
District 2	J. Maxey Dell Jr., M.D., (82)
District 3	Samuel J. Alford, M.D., (82)
District 4	Martin Pepus, M.D., (82)
District 5	John L. Geeslin, M.D., (82)
District 6	James C. Fleming, M.D., (82)
District 7	Robert J. Qualey, M.D., (82)
District 8	Horace Norrell, M.D., (82)
District 9	Francis Pooser, M.D., (82)
District 10	Fred S. Carter, M.D., (82)
District 11	Luis Guerrero, M.D., (82)
District 12	Peter A. Tomasello, M.D., (82)
District 13	Sheldon Zane, M.D., (82)
District 14	
District 15	Norman Gottlieb, M.D., (82)

Blue Shield Board of Directors — The Board selected nominees for election to the Blue Shield Board of Directors from a list of names submitted by the Blue Shield Nominating Committee. Nominees for each physician seat were selected as follows:

Med. Dist. "A"	Herbert Brooks, M.D., Bonifay
(One vacancy - 3 yr. term)	Thomas D. Bartley, M.D., Gainesville
Med. Dist. "B"	David A. Giordano, M.D. (Incumbent)
(One vacancy - 3 yr. term)	W. E. Manry, M.D., Lake Wales
Med. Dist. "C"	John Corbitt, M.D., Lake Worth
(One vacancy - 3 yr. term)	Anthony Vento, M.D., Ft. Lauderdale
At Large	Raymond J. Fitzpatrick, M.D., (Incumbent)
(One vacancy - 3 yr. term)	Daniel Seckinger, M.D., Miami
Laymen	
Med. Dist. "A"	Var Heyl, Gainesville
(3 yr. term)	
Med. Dist. "B"	John A. Turner (incumbent)
Hospital Administrator/ Blue Cross Board Member	Middleton T. Mustian, Tallahassee

Florida State Board of Medical Examiners — In compliance with the House of Delegates' policy, the Board of Governors, taking into consideration nominations submitted by component county medical societies, forwarded recommendations to Governor Reuben Askew for his consideration in making appointments to the Florida State Board of Medical Examiners for terms expiring in 1978.

AMA Councils and Committees — The Board was pleased to submit nominations of Florida physicians for appointment or reappointment to AMA councils and committees.

Medicaid — Authorized the Florida Medical Foundation to continue in pursuing the concept of development of a demonstration project on health care for the indigent through the pre-payment mechanism (open-wall HMO) after appropriate review by the Council on Medical Systems. **(Adopted — R.C. V)**

AMA Hospital Staff Leadership Seminar — Approved FMA co-sponsorship of AMA's Hospital Medical Staff Leadership Seminar to be held in Miami on November 3-4, 1978.

Hospital Staff Privileges — Reaffirmed the current policy of the Association regarding hospital staff privileges: "That membership on the active medical staff is basically created for medical doctors and should be limited to competent and qualified physicians and surgeons and to certain dentists who meet the criteria of the medical staff bylaws; That a section of podiatry may be created and podiatrists granted privileges within their lawful scope of practice; That where the services of certain allied health professionals or semiprofessionals are necessary within the hospital setting, they should be considered for some medical staff affiliation which would allow them to come in on the basis of a medical staff request or consultant; and further, that this staff category should carry no voting rights, no mandatory obligations or committee membership appointments and should certainly not encompass the privilege of the medical order sheet; and that any recommendations they have with regard to orders could be made in the consultation report and the requesting physician determine the feasibility of implementing these orders at his discretion; and further, that they carry no voting rights on the medical staff or in the various departmental meetings of the staff." This will assure the availability of services of these health professionals to the patients as they are needed, but still maintain quality and not open doors to all manner of persons involved in the health delivery field.

Drug Inserts — Expressed opposition to legislation which would require drug inserts containing information other than drug efficacy. **(Adopted — R.C. IV)**

1979 Annual Meeting — Directed that the 1979 Annual Meeting currently scheduled to be held in Lake Buena Vista, Florida, May 2-6, be rescheduled to April 25-29 and that this meeting be moved to the Diplomat Hotel and that all future Annual Meetings be held at the Diplomat Hotel until such time as suitable alternate locations are determined.

Leadership Conference — Approved tentative meeting dates for the FMA Leadership Conference through 1983 and directed that this meeting be held in the Disney World area.

Dr. John Cheleden — The Board unanimously and enthusiastically approved a resolution to be presented to Dr. John Cheleden at the FMA Annual Meeting in recognition for his many years of service and contributions as a member of the FMA Judicial Council:

A RESOLUTION
COMMENDING JOHN J. CHELEDEN, M.D.

Whereas, John J. Cheleden, M.D., a member of the Florida Medical Association since 1950, and a resident of Daytona Beach, Florida, has rendered distinguished service to the Florida Medical Association's Judicial Council since his initial appointment in 1964, including six years as Chairman; and

Whereas, During his tenure on the Judicial Council, Dr. Cheleden has earned the title "Judge" from his colleagues; and

Whereas, Dr. Cheleden has received numerous honors and awards for his untiring work on behalf of organized medicine, including the Florida Medical Association's highest honor, the Certificate of Merit; and

Whereas, Throughout his service on the Judicial Council this remarkable man has performed his duties with a unique sense of fairness, dignity and integrity; and

Whereas, By his personal conduct, Dr.

Cheleden has developed a model for ethical behavior for all physicians to follow; and

Whereas, This distinguished gentleman has met every difficult decision that has confronted him as a member of the Judicial Council with a degree of intelligence, fidelity, and wisdom seldom seen; and

Whereas, Dr. Cheleden, as a physician and "Judge" has exemplified the noblest ideals of character, and his patient and kindly manner has endeared him to all who have been privileged to know him; and

Whereas, The Florida Medical Association, the medical profession, and the citizens of Florida will long remain the beneficiaries of his wisdom and service; it is therefore

RESOLVED, That John J. Cheleden, M.D., be commended by this Association for his distinguished and unselfish service to his colleagues and the citizens of Florida as a member of the FMA Judicial Council.

FMA Councils and Committees

Your Chairman wishes to thank the more than 250 physicians who have served on the Association's councils and committees during the past year and who have devoted countless hours to the many programs in which the Association is actively involved — programs for the betterment of the public health and in the best interest of all the physicians of Florida.

The following is a summary of the Board's activities regarding the recommendations of councils and committees during the past Association year. A complete report of their activities is included in this Handbook.

(Adopted — R.C. No. 1)

Council on Scientific Activities

Continuing Medical Education — The Board has observed that states with mandatory CME requirements apply them to all practicing physicians. These requirements, as well as FMA's, were carefully evaluated.

RECOMMENDATION NO. 7

THAT ALL FMA MEMBERS ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE BE SUBJECT TO THE FULL REQUIREMENTS OF THE CME PROGRAM, AND THAT APPEALS FOR EXEMPTIONS AND EXTENSIONS BE CONSIDERED ON AN INDIVIDUAL BASIS.

1978 Annual Meeting Scientific Program — The Board approved the scientific program presented by Yank Coble, M.D., Chairman of the Council on Scientific Activities, which will allow physicians to obtain up to 20 hours of CME mandatory credit at the 1978 Annual Meeting.

AMA Winter Scientific Assembly — The Board commended Dr. J. Lee Dockery and Dr. Yank D. Coble Jr. for their outstanding and time-consuming efforts in developing the program for the 1977 AMA Winter Scientific meeting held at Miami Beach, December 10-13, 1977.

Diabetes Advisory Council — The 1976 Florida Legislature created the Florida Diabetes Advisory Council and established centers for diabetes education, treatment and research at the state's three medical schools. The FMA, through its Committee on Medical Education, has been monitoring the activities of this council.

RECOMMENDATION NO. 8

THAT THE FMA EXTEND ITS SUPPORT FOR THE WORK OF THE FLORIDA DIABETES ADVISORY COUNCIL IN SECURING FUNDS TO STUDY THE IMPACT OF



A Resolution of Commendation was presented to John J. Cheleden, M.D., of Daytona Beach, for his many years of service as chairman and a member of the Judicial Council. Dr. Cheleden is escorted to podium (left picture) by James G. White, M.D., of Ormond Beach. At center he receives the award from House Speaker Charles J. Kahn, M.D. At right, Dr. Cheleden accepts the commendation, acknowledging the assistance of other physicians and FMA staff members which he said made the award possible.

DIABETES MELLITUS IN THE STATE, THE PRESENT RESOURCES FOR EDUCATION, RESEARCH AND TRAINING IN DIABETES, AND TO IDENTIFY NEEDS RELATING TO DIABETES; AND THAT THE SECURED FUNDS BE ADMINISTERED THROUGH THE STATE UNIVERSITY SYSTEMS/DEPARTMENT OF EDUCATION.

FMA Journal — The Board commended the Editor of the FMA Journal, Gerold L. Schiebler, M.D., for the general excellence of The Journal and for the award given to The Journal by the Florida Magazine Association.

Continuing Medical Education — The Board directed that physicians heretofore exempted from the FMA individual Continuing Medical Education Program be required to begin their first three-year cycles no later than January 1, 1979 (cycle 3); and further that physicians in parttime practice whose required numbers of CME hours have been reduced to levels commensurate with the number of hours they spend in practice per week be made subject to the full requirements of the CME Program for the three year cycle beginning January 1, 1979.

Council on Specialty Medicine

Laetrile — The Laetrile law passed during the 1977 Session of the State Legislature has a provision that states, "should the Board of Medical Examiners find that the use of laetrile is harmful, may recommend that its use be prohibited." The Florida Cancer Council has given testimony to the Board of Medical Examiners on the harmful effects of laetrile and the Council on Specialty Medicine supports their position.

RECOMMENDATION NO. 9

THAT THE FMA ADOPT THE POSITION THAT LAETRILE IS CLEARLY HARMFUL IN THAT IT ENCOURAGES ABANDONMENT OF SCIENTIFIC TREATMENT FOR CANCER. VICTIMS OF THE VARIOUS MALIGNANT DISEASES ARE TRAGICALLY DRAWN TO THIS SCIENTIFICALLY UNPROVEN REMEDY BECAUSE OF THE EASE OF ITS ADMINISTRATION. THIS RESULTS IN THE UNNECESSARY LOSS OF LIFE AND ADDS TO HUMAN SUFFERING.

Moxibustion — The Board reviewed an inquiry from a county medical society requesting an FMA position with regard to the practice of performing acupuncture and moxibustion techniques. Moxibustion is the application of heat to acupuncture points by burning moxa (dried leaves). The end result of this type of treatment could be second or third degree burns.

RECOMMENDATION NO. 10

THAT THE FMA TAKE THE POSITION THAT THE PRACTICE OF MOXIBUSTION IS A CULT.

Home Delivery in Obstetrical Care — The Board reviewed the position of the Florida Obstetric and Gynecologic Society regarding home delivery in obstetrical care.

RECOMMENDATION NO. 11

THAT THE FMA ADOPT THE FLORIDA OBSTETRIC AND GYNECOLOGIC SOCIETY'S POSITION WITH REGARD TO HOME DELIVERY IN OBSTETRICAL CARE:

> **Home delivery is being requested more frequently by patients for a variety of reasons. In many cases it proceeds uneventfully. Better training of medical and nursing staff, better prenatal care and new screening methods, improved maternal health and nutrition and better parent education have all contributed to improve outcome of pregnancy even in the home setting. However, it is not possible, even with excellent prenatal screening, to identify all of the patients who will suddenly develop a serious complication in labor which, if not resolved immediately, may result in death of, or permanent damage to the baby, or in a few patients, death of the mother herself. Even if the mother is transferred to a hospital, the inherent delay in treatment often compromises the chance of a good outcome.**
>
> **For the above reason, the Florida Obstetric and Gynecologic Society is opposed to delivery at home, but encourages all obstetricians and hospitals delivering obstetrical care to explore alternative modes of delivery within the hospital setting which offers maximum safety for mother and baby as economically as possible, and in a manner more conducive to promoting maternal newborn bonding and satisfying needs expressed by couples desiring a family-oriented approach to delivery. The Society encourages prenatal education to more adequately inform women of the value of newer techniques in obstetrical care and of the uncertainties of home delivery, particularly that supervised by inadequately trained personnel.**

Specialty Group Recognition — During a period of prosperity many new medical organizations come into being. Many are worthwhile and will advance medicine. Others will fall by the wayside and may cause decay and destruction of well-founded groups. In order to assist in the formation of and preservation of groups which are worthwhile, certain ideals have been considered in granting FMA recognition to new organizations. The creation of an annual recognition program including guidelines for recognition would replace the current criteria for recognition.

RECOMMENDATION NO. 12

THAT FMA ESTABLISH AN ANNUAL RECOGNITION PROGRAM FOR SPECIALTY GROUPS REQUIRING SUBMISSION OF AN APPLICATION EACH YEAR INCLUDING THE FOLLOWING INFORMATION:

A. Membership roster
B. Current bylaws
C. List of officers and council representatives.
D. Summary of continuing medical education programs.
E. A statement on any planned legislative objectives.
F. Minutes of last annual meeting.

FURTHER, THAT IN ADDITION TO THE ABOVE DOCUMENTATION, THE FOLLOWING INFORMATION BE CONSIDERED BY THE COUNCIL ON SPECIALTY MEDICINE AS GUIDELINES FOR RECOGNITION OF A SPECIALTY GROUP:

1. That its purpose and need not be covered by an already existing organization and must be a

recognized specialty or sub-specialty by the Council on Specialty Medicine;

2. That there is a sufficient number of physicians seeking the privileges of this society;

3. That the organization must have held at least two annual meetings at which a quorum was present prior to the time of application;

4. That a constitution and/or bylaws state its organizational structure, purpose and aims;

5. That the membership will abide by the "Principles of Medical Ethics" of the FMA and AMA;

6. That the organization have an annual meeting;

7. That the organization provide continuing medical education to its members;

8. That the organization have statewide representation;

9. That 100% of the active *eligible* members shall be members of the FMA (this requirement may be waived by the Board of Governors when there are extenuating circumstances); and

10. That the attendance record of the Council representative will be considered at the time of annual recognition.

Electro-convulsive Shock Treatment — There is legislation being urged which would prohibit or restrict the use of electro-convulsive therapy. It is not in the best interest of patient care to legislate matters of medical judgment. The Board expressed opposition to legislation which would prohibit or restrict the use of electroconvulsive shock therapy and which would make individual choice of treatment statutory.

Raw Milk — There is an increasing frequency of physicians writing prescriptions for raw (unpasteurized) milk. Present Florida law prohibits the sale of unpasteurized milk. Nevertheless, a system has been developed for allowing commercial dairies to honor a physician's prescription. The procedure is time consuming and inconvenient for all concerned. Dairymen complain because compensation is far below actual cost. The Health Program Office, Department of HRS, has requested an opinion on this subject.

RECOMMENDATION NO. 13

THAT THE FMA TAKE THE POSITION THERE IS NO SUBSTANTIVE EVIDENCE THAT RAW MILK AS COMPARED TO PASTEURIZED MILK HAS ANY THERAPEUTIC VALUE.

Family Practice Residency Programs — Residents in the family practice programs have expressed concern that their training in pediatrics is sub-standard because pediatricians are not participating in the training program.

RECOMMENDATION NO. 14

THAT THE FMA ENDORSE THE CONCEPT OF FAMILY PRACTICE RESIDENCY PROGRAMS AND URGE ALL SPECIALTY GROUPS TO PARTICIPATE IN THE TRAINING OF FAMILY PRACTICE RESIDENTS.

Bureau of Health Insurance — The Board directed that the Bureau of Health Insurance be contacted with the request that all recognized codes be profiled individually for reimbursement purposes.

Lay Midwifery — The Board supported legislation which would prevent further licenses of lay-midwives.

Abortion Clinics — The Board supported proposed legislation to regulate abortion clinics in the state.

(Adopted — R.C. II)

Council on Medical Services

Ad Hoc Committee on Nutrition — The Board established a special Ad Hoc Committee on Nutrition to study the quality of nutrition in schools and to prepare an FMA position paper on food additives, dieting, and the importance of good nutrition.

Medicaid Reimbursement — The Board authorized discussion with the Department of HRS regarding more efficient processing of Medicaid claims, and to insure that government fee schedules and third party reimbursements for physicians in rural areas be elevated to match those of participating physicians in urban areas.

Whooping Cough — The Board expressed concern over the present epidemic of whooping cough and recommended that all children be properly immunized.

Chlorination of Water — The FMA received a request from the Department of Environmental Regulations seeking input regarding the chlorination of public water supplies.

RECOMMENDATION NO. 15

THAT FMA ADOPT THE POSITION THAT ALL PUBLIC WATER SUPPLIES SHOULD BE CHLORINATED.

FTE Funding for Athletics — The Board observed that proper funding of athletic programs would eliminate most problems associated with medical care of student athletes. Presently there is no FTE (full time equivalency) categorical funding for athletics and legislation would be required to establish one.

RECOMMENDATION NO. 16

THAT FMA SUPPORT THE CONCEPT OF CREATION OF POSITIONS FOR HIGH SCHOOL ATHLETIC TRAINERS, INSURANCE COVERAGE FOR STUDENT ATHLETES AND UTILIZATION OF PROPER ATHLETIC EQUIPMENT.

Ambulance at Football Games — The Board requested medical directors of local EMS programs to encourage ambulances to be on standby at high school football games if feasible.

Athletic Training Grant — The Board authorized the Florida Medical Foundation to seek a grant from an athletic supply company for conducting a survey of high school athletic training programs, and initiating an athletic injury reporting service for Florida.

EMS Communications — There are some EMS systems within the state which do not have basic two-way radio communications. This year there will be limited federal funds available for implementing and upgrading EMS communications networks. The Board concurs that it should be a state priority to have on a statewide basis basic two-way voice communication capability before upgrading any present communications system to include more advanced technology such as "physician interrupt capability."

RECOMMENDATION NO. 17

THAT THE FMA ADOPT THE FOLLOWING RESOLUTION CONCERNING EMS COMMUNICATIONS:

Whereas, EMS constitutes an important part of the health system, and

Whereas, EMS personnel provide lifesaving and morbidity-reducing medical care at the scene of occurrence of the emergency, and

Whereas, Such medical care must be under the responsible supervision of a licensed physician, and

Whereas, Such responsible physician supervision is usually provided via two-way voice telecommunication between the physician and the EMS personnel, and

Whereas, There is not uniform availability, on a statewide basis, of telecommunications capability to permit such two-way voice communications, therefore be it

RESOLVED, That availability of two-way voice communication between a responsible physician(s) and EMS personnel delivering emergency medical care is the minimum acceptable level of care as it relates to EMS, and be it further

RESOLVED, That the Florida Medical Association believes that the health care interests of all Florida can best be served by assuring availability of an acceptable minimum level of care throughout the state on a first priority basis.

EMS Conference — The Board authorized FMA co-sponsorship of a statewide EMS medical directors conference. The purpose of the conference, which was held in Tampa on March 3 and attended by some 125 people, was to provide EMS directors with a good understanding of their responsibilities and liabilities under the EMS Act adopted by the 1977 Florida Legislature.

9-1-1 Emergency Phone System — The Board directed that each county medical society be notified that there is state funding available for implementing the 9-1-1 Emergency Phone System on a statewide basis and requested that the county medical society encourage its local municipalities to implement this system which has lifesaving potential.

Comprehensive Health Education — The Board expressed support for general categorical funding for the state health education program.

Rural Physicians Survey — The Board authorized a rural physician survey to be included in the next regular issue of the FMA "Briefs."

Amphetamines — In Duval County, the local medical, pharmaceutical and osteopathic associations formed a Joint Committee on Amphetamines which recommended: 1) take all amphetamines off drug store shelves; 2) require a 48-hour delay for legitimate prescription verification and filling; and 3) apply the same criteria to methaqualone.

RECOMMENDATION NO. 18

THAT THE FMA ENDORSE THE ACTION TAKEN BY THE DUVAL COUNTY MEDICAL SOCIETY, JACKSONVILLE AREA OSTEOPATHIC SOCIETY AND JACKSONVILLE PHARMACEUTICAL ASSOCIATION TO VOLUNTARILY REMOVE ALL AMPHETAMINES AND METHAQUALONE FROM THE SHELVES OF LOCAL RETAIL PHARMACIES, AND FURTHER

THAT ALL COMPONENT SOCIETIES OF THE FMA EXPLORE THE FEASIBILITY OF A SIMILAR PROGRAM IN THEIR OWN LOCAL AREAS.

Committee on Allied Health Professions

Advanced Nurse Practitioners — The Board approved a high level meeting between representatives of the FMA, the Florida Nurses Association and the SBME for the purpose of seeking solutions to the present disagreements over the rules and regulations for promulgating the new Nurse Practice Act and the role of the advanced nurse practitioner.

As a result of the conference, it was agreed to reconvene the joint advisory committee established by the Act for the purpose of defining additional functions for advanced nurse practitioners.

On February 27th, the State Board of Nursing reconvened its Joint Advisory Committee for the purpose of defining additional functions for advanced nurse practitioners. During this meeting, the Advisory Committee did reach an agreement but, as of this date, the document, which will be known as Appendix A (additional functions) to the rules for the 1975 Nurse Practice Act, has not been published. Therefore, the Committee on Allied Health Professions will withhold any recommendation until it has an opportunity to study these rules in final form.

The agreement reached by the Advisory Committee requires that "additional functions" must be performed within a framework of established protocols with an M.D., D.O., or D.D.S. and the physician will maintain supervision for directing the specific course of medical treatment.

In addition, the previous draft contained a number of provisions which used the terms "prescribe" or "alter." These words,were deleted in favor of the term "initiate." The Advisory Committee defined "initiate" as carrying out the prescription of a physician.

Pharmacists — The Board authorized informal discussions between representatives of FMA and the Florida Pharmaceutical Association and the University of Florida College of Pharmacy regarding proposed pharmacy programs affecting the future role of the pharmacist such as:

1. Awarding the "Doctor of Pharmacy" as the first professional degree;
2. The prescribing role of the Pharmacist;
3. Increasing the clinical aspects of Pharmacists;
4. Encouraging the administration of parenteral drugs by Pharmacists;
5. Opposing dispensing by physicians;
6. Oppose the sampling of controlled drugs; and
7. Limiting the sale of OTC drugs to public establishments where Pharmacists are available for consultation.

(Adopted — R.C. II)

Committee on Voluntary Health Agencies

Recognition Program — Approved renewal of recognition for the following Voluntary Health Agencies.

1. Florida Chapter, Arthritis Foundation
2. Florida Division, Leukemia Society of America
3. Florida Heart Association
4. American Cancer Society, Inc., Florida Division
5. National Foundation — March of Dimes
6. Florida Lung Association
7. United Cerebral Palsy of Florida, Inc.
8. Easter Seal Society for Crippled Children & Adults of Florida, Inc.
9. National Multiple Sclerosis Society, Southeast Region
10. Mental Health Association of Florida, Inc.
11. Florida Society for the Prevention of Blindness, Inc.
12. Florida Association for Retarded Citizens
13. Florida Coordinating Council of the National Kidney Foundation

The Board authorized that recognition be renewed tentatively for 1978-79 for the Florida Epilepsy Foundation and the Chairman of the Committee on Voluntary Health Agencies authorized to make a final determination as the the Agency, pending review of the formal application. **(Adopted — R.C. II)**

Committee on County Medical Society Presidents

Legislative Educational and Public Relations Activities in South Florida — The Board recognized the importance of the South Florida area in legislative and public relations activities as they affect the entire state and the need for these activities in South Florida to be funded at an appropriate level.

State Legislative Communication — The Board directed that county medical societies be advised as to the various types of state legislative information that is available upon request, including the Senate and House calendars, and how this information may be obtained on a regular basis.

Structuring of Committee — The Board authorized that the Committee on County Medical Society Presidents be restructured to provide for membership of other than current county medical society presidents, in order to provide as much continuity as possible to the committee, thus enhancing the Committee's effectiveness.

County Medical Society Grievance Procedures — The Board requested the FMA Judicial Council to distribute to the county medical societies a general outline regarding due process procedures to be followed by county medical societies in resolution of a grievance against one of its members and urge the county medical societies to review their by-laws to be sure they follow due process.

Florida Committee on the Cost of Medical Care — The Board approved creation of a state level committee on the cost of medical care to be comprised of representatives from the FMA, Florida Hospital Association, Blue Cross and Blue Shield, the Health Insurance Council and industry, for the purpose of conducting an indepth study of the factors affecting the cost of medical care and to encourage individual representatives to seek ways of resolving these problems within their individual sectors.

The organizational meeting of the committee was held on Saturday, March 4th. Representatives in the committee include:

J. Lee Dockery, M.D., Florida Medical Association
James F. Richards, M.D., Florida Medical Association
Salvo A. Mudano, Chairman, Florida Hospital Association
Lee R. Ledbetter, Florida League of Hospitals
J. Champneys Taylor, M.D., Secretary, Blue Shield of Florida
G. Emerson Tully, Ph.D., Blue Cross of Florida
Miss Betty Gurney, Vice-Chairman, Florida State Health Insurance Council. **(Adopted — R.C. V)**

Committee on HSA's

PL 93-641 — National Health Planning and Development Act — The Board placed major priority on careful analysis and input into government programs such as PL 93-641 with special emphasis on HSA's and the State Health Coordinating Council.

A special FMA Committee on HSA's was appointed which consists of representatives (M.D.'s) from each of the 9 HSA areas. The committee is chaired by Charles Tate, M.D., Miami.

Minnesota Plan — The Board authorized the HSA Committee to perform in a modified fashion similar to that of the program of the Minnesota State Medical Association which includes:

Establishment of physician health forces in each of the 9 HSA areas in the state and a state HSA committee.

Parallel functions to state and local health planning agencies.

Staffing — That the FMA assign more adequate FMA and county medical society staff to insure effective parallelling of all nine HSA's in Florida.

Guidelines and Activities — The Board approved guidelines under which the FMA Committee on HSA's will function and its activities:

Close scrutiny of state and federal regulations affecting HSA's, particularly health planning guidelines.

Certificate of need — Assist in establishment of local physician committees for the purpose of receiving and forwarding activities of local HSA's.

When appropriate, maintain liaison with FMA recognized specialty groups regarding HSA activities.

Regional meetings — Urged Florida's U.S. Congressional Delegation to monitor HSA regional meetings in order to view first hand the inherent failures of Public Law 93-641. **(Adopted — R.C. V)**

Judicial Council

Physician Trained Assistant — The Board directed that a letter be written to the State Board of Medical Examiners requesting that they obtain an opinion from the Attorney General of the State of Florida, to clarify whether or not a physician may legally employ a trained assistant in his office to carry out medically related activities, including the giving of injections, while under his control and supervision.

Medical Practice Act — The Board adopted a position that FMA aggressively pursue, through the legislative process, additional funding for the Board of Medical Examiners that would allow the Board to hire additional Attorneys to prosecute cases of violation of the Medical Practice Act; and further, that the FMA, through the appropriate



Eric F. Geiger, M.D., Pensacola (right) was the creator of the prize-winning picture that appears on the cover of this issue of *The Journal*. Dr. Geiger's photograph was entered in the Auxiliary Art Show and was adjudged winner of the Editor's Award by the Committee on Scientific Publications. Gerold L. Schiebler, M.D., Editor of *The Journal* (left), was on hand at the Auxiliary Awards Luncheon to make the presentation to Dr. Geiger. Sharing the moment with them is Mrs. R. B. (Connie) Moore of West Palm Beach, President of the Auxiliary.

means, seek to increase the salary of the Executive Director of the State Board of Medical Examiners.

Advertising — The Board requested that the Judicial Council adopt guidelines for advertising routine fees by the members of the Florida Medical Association.

Complaint File — The Board expressed vigorous opposition to any legislation which would require complaint files and reports made to professional licensing boards to be open to the public.

Telephone Directory Listings — At the request of the House of Delegates at its meeting in May 1977, the Judicial Council has continued to study the problem of yellow page listings in an attempt to make compliance as equitable as possible in an effort to suit the needs of all practicing physicians. The councils' activities regarding this endeavor are outlined in this delegates handbook.

RECOMMENDATION NO. 19

TO APPROVE CONTINUATION OF THE CURRENT POLICY OF THE ASSOCIATION GOVERNING THE LISTING OF MEMBERS IN THE TELEPHONE DIRECTORIES (WHITE AND YELLOW PAGES) AS ADOPTED BY THE HOUSE OF DELEGATES IN MAY 1974, AND AMENDED IN JANUARY 1976 AND MAY 1977.

SBME Deputization — Recommended guidelines to be used by the SBME when deputizing members of the Association for conducting investigations under the jurisdiction of the SBME:

A. That the State Board of Medical Examiners not deputize a member of the Florida Medical Association unless specific guidelines for responsibilities and authorities are provided to the deputy at the time of his appointment.
B. That there be a careful and deliberate screening of any proposed deputy appointment.
C. That there be regular monitoring and control of the deputy in matters relating to work product and methods of investigation.
D. That adequate support personnel, including Board of Medical Examiners investigators and legal counsel, be provided as needed to individuals appointed as deputies of the Board.

Advertising — (Not Adopted)

Washington County Medical Society

RECOMMENDATION NO. 21

THAT, IN COMPLIANCE WITH THE FMA CHARTER AND BYLAWS AND THE RECOMMENDATION OF THE JUDICIAL COUNCIL, THE WASHINGTON COUNTY MEDICAL SOCIETY BE CHARTERED AS A COMPONENT COUNTY MEDICAL SOCIETY OF THE FLORIDA MEDICAL ASSOCIATION. (Adopted — R.C. IV)

Council on Legislation and Regulations

Clinical Laboratory Act — Communication has been received from the American Medical Association and several Florida physicians with regard to the proposed federal Clinical Laboratory Act. The major problem in the legislation, as it now stands, is the exemption for physicians who only do work for their own patients. It was noted that the current Clinical Laboratory Act exempts any physician or group of physicians who do work for their own patients, whereas the pending legislation only exempts those groups of physicians of five or less.

The Board requested the support of Florida's Congressional Delegation in eliminating the restrictive exemption for physician's offices in pending clinical laboratory act amendments.

Certificate of Need — Legislation has been filed in Congress (HR 8121) that requires a certificate of need for physician's office equipment if the purchase is in excess of $150,000. This is included in the bill of which the primary subject is hospital cost containment.

The Board placed high priority on working with the AMA in defeating pending legislation which would require certificate of need for physician's office equipment.

1978 State Legislative Program — The Board reaffirmed the Association priorities for the 1978 FMA Legislative program, "Emphasis '78."

Legislation to implement a separate Department of Health mandated in the present draft of the revision to Florida's Constitution, adopted by an overwhelming majority of the 37-member Constitution Revision Commission.

Legislation which would provide for a recovery of defense costs necessitated by inquiries or questionable lawsuits.

The Board has reviewed a number of bills to be introduced in the 1978 session of the Florida Legislature which are of concern to medicine. The following is a summary of the positions taken with regard to these proposed bills.

Optometry — The Board supports legislation (HB 118) which would prohibit use of prescription drugs by optometrists.

Medicaid — Expresses support for legislation to bring about revision of the state's Medicaid program, particularly in the area of total funding.

SBME — The Board supports increased funding for the SBME to enable the Board to carry out its responsibilities including increased authority for the SBME to suspend the license of the incompetent physician to remain in effect until final adjudication.

Acupuncture — Opposes legislation to license acupuncturists in Florida.

Mediation Panels — The Board expresses active opposition to legislation which would abolish mediation panels.

The Board expresses opposition to the following legislation proposals which adversely affect the practice of medicine. The problems these proposals purport to address can more effectively be addressed by other mechanisms.

Regulation of doctor's office equipment through the certificate of need process.

"Truth in Sickness" legislation — The proposal would require physicians and other health care providers to disclose ownership in hospital and other health care facilities on an annual basis to the Department of Health and Rehabilitative Services, as well as furnish to each patient a disclosure of such ownership (HB 547).

Licensure of radiologic technologists — This proposal would include a requirement that all persons who administer x-rays in the State of Florida be licensed by the proposed board.

Attempts to weaken the State Board of Medical Examiners.

Legislation to grant limited hospital staff privileges to chiropractors.

Legislative enactment of a structured fee schedule under the Workmen's Compensation program.

State Commission to regulate hospital and nursing home rates.

Abolishment of mediation panels (HB 419).

Non-judicial mandatory hospital compensation committees.

The Board opposes legislation which authorizes physical

therapists to use acupuncture and which allows treatment by a physical therapist upon "referral" of a physician (SB 155).

The Board opposes legislation removing the exemption for groups of five or less physicians from application of the Clinical Laboratory Act.

The Board opposes provisions to tax out-of-state physicians as a method to provide medical services to medically under served areas.

The Board opposes legislation to mandate that optometrists be appointed to all health advisory committees.

The Board opposes legislation that encourages abandonment of the County Health Department approach in favor of District Health Departments in Florida and urged increased funding for County Health Departments.

The Board disapproves legislation that legalizes the use of DMSO in Florida (HB 734).

The Board acknowledged legislation which allows a patient or his representative to get copies of hospital records upon request (HB 767), and further that previous legal advice has indicated that this bill poses no medical liability problems for physicians.

(Adopted — R.C. V)

Council on Medical Economics

Workmen's Compensation — A summary of the council's activities relating to the Florida Workmen's Compensation medical and surgical fee schedule is included in this Delegates Handbook.

The Board commended Dr. James Richards, Chairman of the FMA Council on Medical Economics, who has worked diligently through his position on the Statutory Advisory Council to Workmen's Compensation to bring about improvements in the medical and surgical w/c fee schedule. The Advisory Council advocated several levels of compensation for office and hospital visits. At the request of the Bureau of Workmen's Compensation Dr. Richards, with the help of Blue Shield, completely converted the workmen's comp fee schedule, a four-digit code, to the appropriate five-digit code as in the 1975 Florida Relative Value Studies.

As a result of this work the Bureau has announced that it will begin to recognize and use both the four and five digit codes and will ultimately convert to the five-digit code. In addition, the Bureau has advised that the initial and final medical reports, w/c c-2 and w/c c-9 respectively, will be revised so that physicians may begin submitting their fees using the five-digit code and reporting the usual and customary charges for services.

The Bureau has also indicated its intention to accumulate usual and customary data for the purpose of providing a statistical base from which future revisions of the fee schedule may be determined.

Relative Value Studies — The Board authorized publication of an interim RVS supplement, effective November 1, 1977, to the 1975 RVS. The supplement was published to provide physicians with a more current reference for reporting Allergy and Clinical Immunology procedures, radiotherapy procedures and several new pulmonary procedures pertaining to newborn infants. These changes reflect updated terminology from "Current Procedural Terminology — Fourth Edition."

Cost of Medical Care — Encouraged hospitals to post at nurses' stations the cost of the 15-20 most common procedures, to educate physicians as to the cost of procedures most commonly ordered.

(Adopted — R.C. V)

Council on Medical Systems

Health Insurance Review Procedures — The Committee on PMUR has given much time and study to the revision of the operating procedures for health insurance review.

RECOMMENDATION NO. 22

THAT THE REVISED OPERATING PROCEDURES FOR HEALTH INSURANCE REVIEW, WHICH ARE INCLUDED IN THE DELEGATES PACKETS, BE APPROVED.

Fee for Health Insurance Reviews — The Board authorized an increase in the administrative fee for review of health insurance cases to $50.00 per case for both county and state review, and requested that FMA staff review the administrative cost of processing health insurance review cases at both the state and county level in order to determine the most appropriate method of costing health insurance review.

PMUR — FMF-Blue Shield Contract — The Board approved renewal of the FMF-Blue Shield Contract for Peer Medical Utilization Review for the period October 1, 1977, to September 30, 1978.

PMUR — FMF-Group Health, Inc., Agreement — The Board approved an extension to the peer review agreement between Group Health, Inc., and the Florida Medical Foundation for conducting Peer Medical Utilization Review in the Dade-Monroe Counties area for the period July 1, 1977, to June 30, 1978.

Bethesda Memorial Hospital — The Board reviewed a resolution adopted by Bethesda Memorial Hospital Board of Commissioners seeking legislative action to combine the annual and/or biennial inspections and surveys of the Joint Commission on Accreditation of Hospitals, the DHRS Hospital Licensure, the State Fire Marshall, the County Fire Marshall and the County Health Department. The FMA and the FHA have been requested to support such legislation.

RECOMMENDATION NO. 23

THAT THE FMA SUPPORT THE RESOLUTION ADOPTED BY THE BOARD OF COMMISSIONERS OF THE BETHESDA MEMORIAL HOSPITAL REGARDING HOSPITAL INSPECTION:

RESOLVED, That the Board of Commissioners of the Southeastern Palm Beach County Hospital District urges the support and action of the Florida Hospital Association, the Florida Medical Association, the American Hospital Association and the Joint Commission on Accreditation of Hospitals in obtaining legislative action to combine the annual and/or biennial inspections, investigations and surveys of the Joint Commission on Accreditation of Hospitals, the state's Department of Health and Rehabilitative Services regarding hospital licensure, the State Fire Marshall, the County Fire Marshall and the County Health Department.

Indigent Health Care — The Board considered a proposed statement on health care for the indigent.

RECOMMENDATION NO. 24

THAT THE FMA ADOPT THE FOLLOWING POLICY STATEMENT ON HEALTH CARE FOR THE INDIGENT:

Statement on Health Care for the Indigent

Access to medical care appropriate to their needs should be available to all regardless of socio-economic status.

Guidance may be needed by the indigent population to appropriately utilize available health care resources. Government and the Medical Profession should cooperatively seek the development of methods for the Medicaid Program to:

A. Encourage the appropriate selection of primary care physicians or facilities.
B. Maintain stability in patient-physician relationship.
C. Foster education in preventive medical care, particularly in the ambulatory setting as opposed to institutional care.

Delivery of health care for the indigent should be in the same setting, both ambulatory and institutional, as it is provided for the rest of the population in order to insure the quality, availability, and economy of health care for all residents.

Administration of the Florida Medicaid Program should be restructured to encourage the cooperation of staff and health care providers at the community level in planning, policy and delivery of health care and permit flexibility in the development of delivery and payment methods appropriate to a variety of community needs. There should be cooperation in terms of interrelation of forms that mesh smoothly with the on-going health care program.

Funding should be realistic, oriented toward ambulatory care and in accordance with acknowledged objectives with public accountability of expenditures delineating administrative costs and health service reimbursement.

Blue Shield of Florida, Inc. — The Board received a report on the activities of Blue Shield of Florida, Inc. Blue Shield had obtained a rate increase which should allow for a build-up reserve. There have been major improvements in Medicare B performance. Blue Shield is currently studying the question of second opinions but has no plans at the present time for extending coverage for second opinions.

Blue Shield is mandated by HEW, in accordance with the Freedom of Information Act, to assemble information on all fees paid to physicians under Medicare B for both assigned and unassigned claims and have this information available to the public upon request by April 30, 1978. Physicians will have an opportunity to review the information as to correctness prior to its release. Blue Shield had no option but to comply with the regulation. FMA is gravely concerned over this unwarranted action by HEW and the intrusion of privacy.

Blue Shield Medical Necessity Project — The Board endorsed the action taken by Blue Shield in regard to their medical necessity project and authorized further study for additional operative, medical and diagnostic procedures that should be disallowed.

RECOMMENDATION NO. 25

AMENDMENTS TO THE BYLAWS

AFTER CAREFUL CONSIDERATION, THE BOARD OF GOVERNORS RECOMMENDS TO THE HOUSE OF DELEGATES ADOPTION OF THE FOLLOWING AMENDMENTS TO THE FMA BYLAWS:

Chapter II; MEETINGS, Section 2 — Special Meetings

DELETE the last paragraph of Section 2 which reads:

> A special meeting shall be called by the President upon written request from five or more component societies, or upon written request signed by at least ten percent of the total Association membership.

This amendment eliminates the provision for a special meeting of the Association.

Chapter IV, HOUSE OF DELEGATES, Section 3 — Called Meetings

AMEND Section 3 to read:

> The House of Delegates may be called into special session by the President. He shall be required to call a meeting of the House of Delegates upon written request of ten percent of the current delegates AND TEN PERCENT OR MORE OF CURRENT, CHARTERED COMPONENT SOCIETIES, or any ten percent of the total Association membership, or upon a three-fourths vote of the Board of Governors. Failure to accede to any such request shall be considered authority for the meeting to be called by the Speaker of the House of Delegates. Except in emergencies, delegates shall be notified in writing of a called meeting at least thirty days prior to the date of the meeting. The purpose of the called meeting and its agenda shall be stated in the notice calling the meeting. THE CALL OF A SPECIAL SESSION OF THE HOUSE OF DELEGATES BY THE METHODS PROVIDED IN THIS SECTION SHALL BE RATIFIED BY MAIL AT LEAST FIFTEEN DAYS PRIOR TO THE DESIGNATED HOUR OF CONVENING OF SUCH CALLED MEETING.

This amendment establishes a requirement of ten percent of the county medical societies and ten percent of the total delegates for a called meeting of the House of Delegates.

Chapter VII, Board of Governors, Section 2, Item 12

AMEND by changing the name of Standing Committee Number 3 from "County Medical Society Presidents" to "COUNTY MEDICAL SOCIETIES."

Chapter VIII, COUNCILS, Section 3, Item 1, Paragraph 3, Duties, Functions and Composition

AMEND the first sentence by deleting the words "and one as the chairman of the Committee on Membership and Discipline."

Chapter VIII, COUNCILS, Section 3, Item 4, The Council on Medical Services

AMEND by deleting the words "Emergency Medical Services and Medical Tele-Communications," and inserting "EMERGENCY MEDICAL SERVICES AND EMERGENCY COMMUNICATIONS."

This amendment effects a change in the name of the committee.

Chapter IX, COMMITTEES, Section 1, Organization, Council on Specialty Medicine

AMEND the second paragraph to read:

> Each representative on the Council on Specialty Medicine SHOULD BE SELECTED annually by the specialty group which he represents and may be re-selected to as many terms as the represented organization so desires. An alternate representative may be selected at the same time

and reported along with the REGULAR REPRESENTATIVE.

This amendment modifies the method of composition of the Council on Specialty Medicine.

The Speaker announced that by approving the report of the Board of Governors, the resolution of commendation offered to Dr. John Cheleden, for his many years of service on the FMA Judicial Council, had been approved.

The Speaker requested Dr. Cheleden to come to the podium to receive this resolution.

Dr. Cheleden expressed his heartfelt gratitide and humble acceptance of this honor by his fellow physicians.

Dr. Cheleden was accorded a standing ovation by the House.

The motion of the Reference Committee that the Supplemental Report of the Board of Governors be adopted as written with the exception of those items referred to other Reference Committees carried.

Supplemental Report Board of Governors

The following supplemental report of the Board of Governors has been prepared summarizing activities which were not included in the Board's report in the Delegate's Handbook.

Litigation — During the past few months the FMA has been subject to federal government interrogation of its activities. The following is a summary of those areas which have been subject to this investigation and/or litigation and their status:

IRS — A special audit of the Florida Medical Foundation (closed)
Revocation of FMA mailing permit (pending)
Federal Election Commission — Investigation of FLAMPAC activities (pending)
Federal Trade Commission — Review of FMA activities regarding restraint of trade (investigative)
Justice Department — Anti-Trust investigation regarding alleged Sherman Anti-Trust violations (closed)

Standardized Claim Form — (Filed — R.C. V)
HEW Release of Physicians' Fees — (Filed — R.C. V)

Council and Committee Structure — The Board approved the following changes in the FMA Council and Committee structure:

1. Council on Medical Systems
   a) The Committee on Government Programs was discontinued.
   b) The Committee on PMUR was transferred to the Florida Medical Foundation
   c) The Committee on Hospitals and Extended Care Facilities was discontinued, and a physician representative for hospitals was appointed as a member of the Committee on Allied Health Professions.



Retiring President and Mrs. Louis C. Murray, M.D., Orlando (left); incoming President and Mrs. O. William Davenport, M.D., Miami.

d) The Council on Medical Systems is composed of the following Committees:
1. Committee on HSA's
2. Committee on Medicaid and Foundations
3. Committee on PRO (the Committee on PRO is composed of the FMA's representatives to the Florida Health Data Corporation).

2. Council on Medical Economics
a) The FMA representatives on the Florida Committee on the Cost of Medical Care will report to the Council on Medical Economics.

3. Committee on Health Insurance
a) The FMA Committee on Health Insurance will assume the responsibility for the FMIT Committee and perform its function.

Florida Physicians' Insurance Reciprocal — The Board of Governors approved the nomination of Thomas B. Thames, M.D., as a fifth director of the FPIR for a four year term and also approved the reappointment of O. William Davenport, M.D., for a five year term. Other members of the Board of Directors of the Reciprocal are: Vernon B. Astler, M.D., Chairman; Jack A. MaCris, M.D.; and Richard S. Hodes, M.D.

Florida Medical Foundation — The Board of Governors approved the following nominations for appointments to the Board of Directors of the Florida Medical Foundation: Eugene G. Peek Jr, M.D., President; Thomas B. Thames, M.D., Vice-President; Donald G. Nikolaus, M.D., Vice-President; Theodore J. Marshall, M.D., Vice-President; and W. Harold Parham, D.H.A., Secretary-Treasurer.

Pinellas County Resolution — The Board of Governors reviewed a resolution from the Pinellas County Medical Society proposing a change in the FMA bylaws with regard to regular and called meetings of the House of Delegates. The FMA bylaws require that proposed changes in the bylaws must first be studied by the Board of Governors. It was noted that recommendations relating to this matter were included in the Board's report to the House. The proposed requirement regarding delegate attendance was referred to a special committee of the Board for further review and recommendations.

Continuing Medical Education Records — The House of Delegates in 1977 adopted a resolution that the FMA explore methods for reporting and monitoring CME records and develop as soon as practical and feasible a centralized system for maintaining CME records. This has been under intensive review through the FMA Committee on CME. The Board approved the establishment of a simplified method of reporting CME similar to that implemented by the Pennsylvania Medical Society. Essentially, a record will be kept of information provided by physicians reporting in their CME at the end of a three-year cycle. A notice will also be sent to physicians in advance, notifying them of their reporting date. **(Adopted — R.C. I)**

Medicaid-PMUR Contract — (Filed — R.C. V)

Supplemental Report Board of Governors

Blue Shield of Florida, Inc. — Medicare

Resolution 77-25

[NOT ADOPTED — Referred to Special Committee]

Whereas, The Florida Medical Association originally endorsed and sponsored Blue Shield of Florida, Inc., with individual physicians initially providing the funds to organize the Corporation in order to pay for service benefits for low income citizens of Florida; this endorsement by the FMA is still in effect, with members of the House of Delegates of FMA comprising the active membership (Corporate Body) of Blue Shield, and

Whereas, the House of Delegates of the FMA requested Blue Shield to serve as the fiscal intermediary for the administration of Medicare, Part B., in the State of Florida, as the program then existed, and

Whereas, the FMA House of Delegates referred Resolution 77-25 to the FMA Board of Governors, and

Whereas, Blue Shield's contract with the federal government in reality has become an open-end contract which requires it to carry out all directives as mandates of the Social Security Administration, and

Whereas, it was necessary for the FMA to seek a preliminary and permanent injunction in Federal Court to prevent Blue Shield and the federal government from releasing financial data regarding individual physicians and their patients under the Medicare program and

Whereas, This month the Social Security Administration has directed that a dual fee schedule be established in the State of Florida by Blue Shield and GHI, which is contrary to established policy of this House of Delegates, and

Whereas, The Board of Governors of the FMA has been repeatedly assured by Blue Shield that they are not financially dependent on their contracts with the federal government, and

Whereas, Several of these mandates of the federal government being implemented by Blue Shield would be a disservice to the physicians of this state and the rendering of medical services, therefore be it

RESOLVED, That the FMA withdraw sponsorship and endorsement of Blue Shield of Florida, Inc., serving as the fiscal intermediary for Medicare, Part B., in the areas of Florida which it serves, and be it further

RESOLVED, That Blue Shield of Florida, Inc. be requested to terminate its contract with the federal government as fiscal intermediary for Medicare, Part B., at the termination of its present contractual obligation and in no event later than one year, and be it further

RESOLVED, That in the event that Blue Shield of Florida is unable to accomplish this in one year, then it would become necessary for the FMA, through action of the House of Delegates, to terminate its affiliation with Blue Shield of Florida, Inc.

Report of Public Relations Officer and Supplemental Report, Public Relations Officer

The Reference Committee considered the reports submitted by Dr. Vernon B. Astler, Public Relations Officer, and commended Dr. Astler for the extensive work that has been accomplished in this area.

The motion of the Reference Committee that the report of the Public Relations Officer be adopted as printed in the handbook carried.

Public Relations

Vernon B. Astler, M.D., Public Relations Officer

The major achievement for 1977 was the stabilization of the overall public relations program. The successful pilot efforts of 1976 were strengthened and realigned.

Since the formation of the Public Relations Department in 1976 as a three-person office, many advances have been made to inform the public of the activities of the Florida Medical Association on a grass roots level while attaining national recognition with the production of our two television documentaries.

Combining foresight and a firm grasp of present realities, we can

meet the crisis with which many areas of organized medicine a e burdened today. We have a dual challenge in terms of communications during this period.

First, communications within our own medical community is vital to assure physicians that their association is moving forward to meet the challenges.

Second, communications and public relations are essential with the public at large and specific groups within the public including general opinion leaders such as corporate executives, government officials and public affairs officers.

The use of material by the media throughout the state has continued to grow, indicating that we have found the right channels and presentation for utilization of FMA material on a consistent basis.

The Association expanded its effort to advance the overall image of the physician and to convey through all of its services the basic themes illustrating the high quality of medical services and health care enjoyed by Floridians.

1. **Films.** In January and October of 1977, major television outlets broadcast dramatic presentations of quality medical care and practical preventive medicine to thousands of Floridians. These documentaries, showing many aspects of medical care seldom seen by the public, was part of the continuing image development and outreach of your Association.

These successful efforts are examples of the long-range public relations program adopted by the FMA to meet the challenges that the practice of medicine faces today.

The first film, "A Matter of Life . . ." and the second film, "It's Your Life . . ." have demonstrated what can be accomplished by the use of the high impact public relations item. The unique value of these films in penetrating public consciousness is demonstrated by survey findings and the fact that we were ahead of the market in medical documentary interest is attested by the recent network special. The FMA productions continue to be unique specials for use by television in the years ahead, as well as the many additional uses by schools, civic groups, hospitals, etc. The FMA productions mesh well with the network interest in the subject and illustrate that we should continue to have high interest by viewers in the future. The FMA plans to reshow the films with appropriate promotional effort in the future.

A particular breakthrough in 1977 was the significant promotional campaign mounted for our second film, which produced a major degree of awareness of the film showing.

Over 100 civic groups, schools, universities, hospitals, churches and others have used the two films for their organizations. They have been shown in a number of states at national medical meetings, as well as to numerous lay professional groups.

2. **Field Offices.** Through the establishment of the new field offices in South and Central Florida and the Capital Office in Tallahassee, the Association is developing an in-depth and integrated program for public relations, legislative education and activities, and political education. These new offices are to augment and assist county medical societies with programs and activities.

3. **Public Service Announcements.** The use of the public service announcements for television produced by the FMA continue to demonstrate the value and receptivity of this type of outreach.

Two new public service announcements were produced this year. One was released last June, and the third spot was released the end of February. This is an area where we have received many requests for additional programming of this type.

There is every indication that the FMA message is being seen by hundreds of thousands of Floridians.

4. **Radio.** In addition to radio news comments, the five-minute radio program, using physicians on a regional basis was renewed. Initial reactions have been excellent. The Association inaugurated, at the request of many radio stations, a series of 60-second medical messages taken from the five-minute programs. These have a high degree of interest and are well received. The radio tapes are sent out on a monthly basis with two five-minute programs and four 60-second spots per tape. Ten radio programs have been released since last October. Eight more have been recorded and will continue to be released on a monthly basis.

5. **Speaker's Bureau.** The Speaker's Bureau, headed by Edward R. Annis, M.D., has demonstrated the positive value of this concept. Initial response has been superb, and we are penetrating the hard-to-reach leadership market.

Following the initial mailing of material announcing the availability of speakers from the FMA Speaker's Bureau, the FMA received a total of 16 requests for the services of Dr. Annis. Dr. Annis has addressed nine statewide organizations. Other members of the Speaker's Bureau have spoken to county medical societies and local civic organizations.

6. **Print Media.** New breakthroughs were achieved in placing the column in many additional print sources beyond the weekly press opportunities. These included employee publications, hospital and other health agency organs, and the continued expansion of the column into the daily and weekly press.

A. Numerous requests for specific columns have been received which indicates a sincere interest in the column by publishers. Thirty-one county medical societies co-sponsor the column.

B. News releases produced weekly continue to generate a great deal of interest on the local level, and are being utilized with increasing frequency. During any given week, FMA releases can be seen in about 50 publications, half of which use the material on a regular basis. Hospital newsletter editors and editors of company publications have been added to our mailing list this year. A true barometer of the usage can be seen in the releases dealing with "It's Your Life . . ." promotion. The material appeared in print free of charge in every area of the state, including Dade, Duval, Orange and Hillsborough Counties. In most cases, the material received excellent play, rather than use as a filler. Continual flow of weekly news releases is obtaining high column inches.

C. The Association began to produce significant regular features which have found a high degree of acceptance, particularly on a regional basis. This different approach to getting the medical story into print has met with success. In an effort to "publicize" the second annual Physician Recruitment Conference October 29, 1977, in Gainesville, four feature stories were developed on rural physicians. The stories, averaging four pages in length, were sent to newspapers in the geographic areas surrounding the locales of the four featured physicians. Two of the four stories were accompanied by photographs.

7. **Annual Meeting.** The Annual Meeting was thoroughly publicized and documented in the news releases before and after the meeting. Many of the releases (on officers and award winners) were tailored and distributed to individual markets to increase usage.

A number of press conferences were arranged for Jack MaCris, M.D., Immediate Past President, and President Louis C. Murray, M.D., as well as coverage of major events. The live coverage in Miami afforded the Association an invaluable opportunity to cultivate media contacts which will be useful at future meetings.

8. **Journal of the FMA Review.** News releases dealing with articles appearing in the Journal are being written monthly. The most recent release for which we have clippings received excellent response, plus phone requests for the **Journal** by approximately two dozen media outlets.

Future articles of general public interest are now screened well in advance of publication for consideration as news release material.

9. **Television Appearances.** Interviews have been arranged between President Louis C. Murray, M.D., and television stations around the state. The purpose of these interviews is to provide an

outlet for FMA stands on national health insurance, legislation and general information.

The motion of the Reference Committee that the Supplemental Report of the Public Relations Officer presented at the first meeting of the House also be adopted carried.

Supplemental Report
Public Relations Officer

It doesn't take a genius to understand that our profession has been under attack and in battle and is being hit from every side. We just heard a report from our Executive Vice President as to the nature and the weight of bureaucratic control when they bring that weight down upon you. They have many untold ways to harass private and free enterprise organizations such as ours, and they're not unaware of some of the things we've done such as instigating this suit to prevent the release of physicians' names and numbers with regard to recovery under Medicare and Medicaid.

Operating on the principle that no one is going to tell your story if you don't tell it, or if you don't respond, this Association two and one-half years ago embarked on a very ambitious communication and public relations effort. At that time, we recognized individuals on the other side were telling their story, but our story was not being completely or factually told; and survey after survey, paradoxically enough, tells us that physicians still rate the highest among vocational people and among professions, and yet we are being attacked continually.

The problem was how to challenge this attack with a counter-attack, and how to get our story across. You and I are health professionals. We know how to diagnose, how to treat, but perhaps we're amateurs in the public relations field. We hired some professional help and this was headed by Roy Pfautch and Carolyn Kenyon; they've gone a great way to leading this charge, and I am here to tell you, in this area also, your Association is succeeding. We are starting to get this message across. The message is that we have the best health care system in Florida, and that system, which is basically the free enterprise system of health delivery, is better not tampered with. This is the message that hopefully, in a subtle way, we're getting across.

What are some of the highlights of the year? You have a lot of printed material in your handbook, and I'm not going to reiterate all of this, but I can emphasize, or focus on, a couple of points. If imitation is the sincerest form of flattery, then we are being flattered; because they are calling us from all across the country — from different state associations and various counties — asking us how we've done this public relations thing; how we've headed it up; what our thrust has been; and what we're doing basically.

We're covering various areas: Newspapers — we learned early that these newspapers are hungry for basic health news. A recent survey showed 86% of the readers they polled from newspapers looked for and read basic health hints. It's not enough for us to supply the hints alone; we take a positive thrust that gives one or more of our themes in conjunction with the health hint. [Slides shown] These are just some of the clippings we've picked at random and published. The second slide shows a medical column called "Medical Message." This is being recognized all over the nation as being one of the most professionally executed and attractively designed columns. It is now being presented in 172 weekly and daily newspapers in this state, from the Jacksonville Times-Union to the Daytona Journal, the Sarasota Herald, the Lakeland Ledger — All the way to the Taco Times in Perry, Florida.

Again, the health message is to be able to make a positive progressive point telling what you are doing to serve the public.

Another achievement has been in the placement of a column in the publications of major Florida employers — industrial employers and many charitable and hospital newsletters. The next slide shows some of the things which have been published by these folks, and over one million readers now absorb this Florida Medical Message twice a month.

Radio and Television — Let's move over to the area where everyone sees or hears the impact. Forty percent of the stations in Florida are now using our five-minute medical message program. In response to many requests we have added a one-minute message, which is being well received. This slide shows the results of a sample questionnaire sent out to radio stations showing overwhelming approval of both the five- and one- minute programs. We are now planning adaptation for publication of some of these in Spanish for areas of the state where Spanish-speaking people are heavily located. We also have plans for a beeper network to beam instantly major comment when a timely news story concerning a medical matter breaks in the state. You and I may not look at too much television, but we're a minority — most Floridians do. The key to breaking into television is quality — quality and contacts. Last year we showed 30-second public service spots which contained a strong message in behalf of our profession. These spots with pro-health information have run free on all major stations in Florida, and if we added up the total commercial time, we'd be talking about over $600,000.

The major electronic achievements of 1977-78 were our films. The first film "A Matter of Life . . ." won plaudits all over the state and is still being shown to countless civic organizations and educational groups. Quite frankly, this film, like any good film, should be re-run periodically and we asked the county medical societies to sponsor and encourage the showing of this film. Do it locally and put your weight and your help behind it.

We didn't know how the second film would be received. It was a little touchier subject, telling people what they could do for themselves and their own health, and it was called "It's Your Life . . .". The next slide shows something of the response we received from this. It was tremendous. A survey was done by 6 prominent Florida research firms and they will testify to the overwhelmingly favorable response from the viewing audience of over one million people who saw this second film. In the panhandle of our state, one station said they wanted to show it again, and they wanted to show it on prime time, and they would pay the costs. University after university has made it mandatory viewing, and school system after school system has come aboard and asked for this film in addition to the first film. Recently the Florida Heart Association gave us a special recognition with its public service award. The impact of these two films has been literally amazing.

Your success story. Clearly, the public wants to hear from us; and obviously, we're getting the message across. For those of you who have not seen these films, they will be shown continuously in the Exhibit Area in booth 40 during the course of the convention, and I urge all of you who have not seen them to stop and look them over. We will probably have a new film this year. It's in the planning stage now, and I can't give you much more than that, but we're working on it and we think it's going to go across even better than the first two. The Speaker's Bureau which our President, Dr. Murray, alluded to, has been headed up by community physicians in various counties offering their time to give speeches. Ed Annis personally has been a tower of strength in travelling around the state and giving talks in his own eloquent way.

Now, let's put it all into context. We've taken the public relations effort out of the defensive posture and we've taken to the offensive. We are reaching out daily to remind the public of what our profession is accomplishing and what we are accomplishing in their behalf. I think

the year ahead offers new and challenging possibilities. I think, of course, this House deserves congratulations for its willingness to accept this comprehensive effort; and naturally, it's easier to assimilate when we know we are succeeding and getting recognition. The reward is there.

In the last analysis, the public relations program is only one part of our total commitment to insist that the destiny of medical practice be in the hands of the profession. This is the message and this is the theme which your public relations program is building. In many ways, the response indicates clearly that we are winning where it counts — with the people we serve.

Thank you very much.

Committee on AMA Delegates

The motion of the Reference Committee that the Report of the Committee on AMA Delegates be adopted carried.

Committee on AMA Delegates
James T. Cook, M.D., Chairman

It has been my pleasure to serve as chairman of the AMA Delegation during the past year and I greatly appreciate the assistance of the Vice Chairman, Burns A. Dobbins, Jr., M.D., Fort Lauderdale. I wish to thank all the delegates and alternates who have given of their time and efforts in support of the best interests of Florida's physicians in the AMA's House of Delegates: Rufus K. Broadaway, M.D.; Richard G. Connar, M.D.; Samuel M. Day, M.D.; Charles K. Donegan, M.D.; Joseph C. Von Thron, M.D.; Vincent P. Corso, M.D.; Eugene G. Peek, Jr., M.D.; T. Byron Thames, M.D.; William J. Dean, M.D.; Francis C. Coleman, M.D.; Jack Q. Cleveland, M.D.; and Vernon B. Astler, M.D.

Florida's delegation has become a respected voice in the House of Delegates and several of our delegation hold important council and committee assignments: Burns A. Dobbins, Chairman, AMA Judicial Council; Rufus K Broadaway, Chairman, AMA Council on Long Range Planning and Development; Richard G. Connar, Member, Council on Medical Education. Joe Von Thron is a member of the AMPAC Board. Several of our delegates were also asked to serve on reference committees at the annual meeting in June and the interim meeting in December.

I would particularly like to commend our alternate delegates for their interest and full attendance at all meetings and for their assistance at reference committees and at sessions of the House of Delegates.

AMA President Elect — The Florida delegation with the full and enthusiastic support of the FMA Board of Governors is pleased the FMA will place the name of Jere W. Annis, M.D., Lakeland, in nomination for the office of AMA President-Elect at its annual meeting in June in St. Louis. Jere is eminently qualified for this office and the entire delegation is diligently working to bring about his election.

Benjamin Rush Award — A highlight of the AMA Interim Meeting in December was the presentation of the 1977 Benjamin Rush Award for community service to Luis M. Perez, M.D., Sanford, Florida. Dr. Perez is well known to many of us in Florida. His nomination by FMA for this award is testimony to his many contributions to both organized medicine and his community. In 1971 he was named recipient of the A.H. Robins Award for community service by a physician. The doctors of Florida can be proud that a fellow physician was awarded this high AMA honor.

House of Delegates Actions — Your delegates and alternates attended the AMA Annual Meeting in June 1977 in San Francisco and the Interim Meeting of the House of Delegates in December 1977 in Chicago. All major activities of the House of Delegates have been reported in the **AM News** and the following is a summary of the FMA delegates' activities regarding matters considered by the AMA House of Delegates which are of major concern to the FMA:

Resolution 77-64A CME Category I Credits for Attending Meetings of the AMA House of Delegates — This resolution introduced by the Florida delegation resolved that CME Category I credit be awarded to all members, officers and delegates who attend any meeting of the AMA House of Delegates.

Testimony before the reference committee pointed out that meetings of the House did not meet the criteria for Category I credit for CMA and this resolution was not adopted.

Resolution 77-65A Health Data Reporting System — This resolution, adopted by the FMA House of Delegates in May 1977, resolved that the House of Delegates of the AMA ask the elected representatives in Congress to seek alteration of Section 708 of PL 94-484, the Health Professions Education Assistance Act of 1976, which singles out physicians and dentists as one specific group for invasion of privacy.

This resolution was considered at the Annual Meeting in San Francisco along with several others dealing with this subject. The House concurred in the views expressed in this resolution but felt the whole question of amendment to PL 94-484 required further study and this was referred to the Board of Trustees for report to the House at the 1977 Interim Meeting.

The House of Delegates at its Interim Meeting in December 1977 adopted Report M of the Board of Trustees in lieu of Resolution 65. Report M responded to Resolution 65 (A-77) and contained the amendments prepared by the Council on Legislation to carry out the intent of Resolution 65 (A-77).

Resolution 57 Opposition to National Guidelines for Health Planning — The Florida delegation authored amendments to this resolution which was ultimately adopted by the House of Delegates. Because of the importance of this issue, the resolves of this resolution are set forth in this report for the information of the FMA House of Delegates

RESOLVED, that the American Medical Association strongly oppose the content of the National Guidelines for Health Planning, as published in the "Federal Register" on September 23, 1977, as arbitrary and insensitive to local needs, and that the AMA also strongly oppose the manner in which these standards were compiled and promulgated; and be it further

RESOLVED, That the American Medical Association embark on an immediate study to verify the drastic effect on hospital and medical services that could result in the various communities by implementing the current proposed National Guidelines for Health Planning, and if this in fact be true; and be it further

RESOLVED, That the AMA and its constituent associations, in cooperation with other medical facility authorities, widely publicize through the media the deleterious effects of these ill-conceived regulations, and name the individual hospitals that may be involved; and be it further

RESOLVED, That the AMA support the principle that the local and regional Health Systems Agencies with their indigenous problems establish their own criteria for medical facilities; and be it further

RESOLVED, That the federal regulations that do result be based on the local criteria.

FMA Speaker's Bureau

The Reference Committee commended Dr. Edward R. Annis for the establishment and operation of this highly effective effort.

The motion of the Reference Committee that the Report of the FMA Speaker's Bureau be adopted carried.

FMA Speaker's Bureau

Edward R. Annis, M.D., Chairman

The FMA Speaker's Bureau has demonstrated the intrinsic value of personal contact. Initial response has been excellent and the FMA has penetrated the hard-to-reach leadership market.

Following an initial mailing of material announcing the availability of speakers from the FMA Speaker's Bureau, a total of 16 requests have been received from either national or statewide organizations.

FMA officers and other members of the Speaker's Bureau have addressed county medical societies and other civic organizations.

A letter will be mailed offering the services of the FMA Speaker's Bureau to the current officers of major state and national organizations.

The Association will escalate the Speaker's Bureau Program for county medical societies by letter and FMA publications.

Committee on County Medical Society Presidents

The motion of the Reference Committee that the Report of the Committee on County Medical Society Presidents be adopted carried.

Committee on County Medical Society Presidents

Donald G. Nikolaus, M.D., Chairman

The Committee held one formal meeting during this past Association year, on March 4, 1978. The committee's recommendations have been submitted to the Board on a number of items referred to the committee for review. The following is a summary of the committee's actions.

Resolution 77-18 — "Relation between FMA and component county medical societies" introduced by the Monroe County Medical Society was referred to the Committee for review and recommendations. The committee reviewed the substance of this resolution and received a report regarding the procedures followed by the FMA Judicial Council in investigating complaints against members of the Monroe County Medical Society. It was the opinion of the committee that in regard to complaints filed against members of the Monroe County Medical Society, the Florida Medical Association Judicial Council conducted its investigation in accordance with the Florida Medical Association Bylaws and followed appropriate procedures.

FMA Branch Offices — The committee received a detailed report regarding the establishment and role of the FMA branch offices in Central and South Florida. The committee observed that while the opening of the branch offices was a positive step in improving liaison and communications between FMA and its component county medical societies, more direct personal contact by the FMA leadership and executive staff was desirable. The committee also felt it important that FMA recognize the influence of the South Florida area in legislative and public relations activities as they affect the entire state and that FMA legislative educational and public relations activities in South Florida be funded at an appropriate level.

FMA Communications — The committee reviewed the various formats used by FMA in its newsletters for communication with the FMA membership. The committee also reviewed the catalogue of various public relations activities being carried on throughout the state on a regular basis. There was particular interest in the medical message column and the FMA Speaker's Bureau. The committee also expressed a need that all county medical societies be advised as to the various types of state legislative information that is available upon request including the senate and house calendars, and how this information may be obtained on a regular basis.

Committee Structure — The committee felt that the Committee on County Medical Society Presidents can be a valuable link between FMA and its component county medical societies for liaison and communications. It was felt however that in order for the committee to be effective, there should be as much continuity as possible in making appointments to this committee.

County Medical Society Grievance Procedures — The Committee discussed the current rules and procedures followed by the FMA Judicial Council and county medical society grievance committees in resolution of grievances against FMA members. Several county societies have expressed concern as to whether they were following proper due process in their grievance procedures. The committee recommended to the Board of Governors that the FMA Judicial Council be requested to distribute to the county medical societies a general outline regarding due process procedures to be followed by county medical societies in resolution of a grievance against one of its members.

Florida Medical Foundation

The Reference Committee considered the report of the Florida Medical Foundation and urges that FMA continue efforts to collect delinquent student loans.

The motion of the Reference Committee that the Report of the Florida Medical Foundation be adopted carried.

Florida Medical Foundation

Eugene Peek Jr., M.D., President

An active role by The Florida Medical Foundation has continued during the past year. The following is a summary of its activities. Other programs and activities are outlined in the report of the Board of Governors and in reports of Councils and Committees included in the Delegates' Handbook.

Peer Medical Utilization Review — The Foundation renewed its contract with Blue Shield to continue to conduct Peer Medical Utilization Review. Under the contract, the Foundation coordinates all local medical peer review activities with the state medical peer review committee and the appeals process in all counties except Dade and Monroe counties. The Florida Medical Foundation has renewed its contract with Group Health, Inc. (GHI), the fiscal intermediary for Dade and Monroe, to do peer review in the same manner as for the rest of the state.

A contract was signed October 31, 1977, between FMF and DHRS to provide PMUR for the Florida Medicaid Program. The contract culminated almost four years of discussion with DHRS and is part of FMA's continuing efforts to assist in bringing about improvements in the state's Medicaid Program, including peer review within the private sector for physicians' services.

The activities of the PMUR Committee, chaired by Frank B. Hodnette, M.D., are summarized in the report of the Council on Medical Systems included in the Delegates Handbook.

Medical Student Loans — The Student Loan Program continues in a moratorium due to serious collection problems with numerous loans which affect the solvency of the funds. A complete resume of the program has been compiled in an effort to show the current status of the program.

Currently, there are 69 In-School Loans with a face value of $163,605.70. Of these, 26 are delinquent and have a face value of $54,553.17. Within the past week, one has agreed to pay the bank approximately $800 interest and begin making monthly payments of $150.

There are 75 Repayment Loans with a face value of $176,971.14 and 7 are delinquent, having a face value of $19,247.42.

Since inception of the Student Loan Program, there have been, in addition to the active loans, 55 loans totalling $67,800 made and repaid. We were forced to file suit in only one case and recovered the loan plus attorney fees in that case.

The Florida Medical Foundation has paid four defaulted loans in the amounts of $5,960.64, $2,118.08, $8,421.72, and $4,804.59, for a total of $21,305.03.

One started repayments and reduced his outstanding balance to $1,935.64. However, no payments have been received from him since October, 1976. None of the other three have made any payments. None of the four are members of the Florida Medical Association according to the 1978 Directory.

Caduceus Prints — The Foundation continues to make available for a $300 donation, prints of the "Caduceus" by Lee Adams. There has been $53,300 received from this source since the prints were made available in December 1975.

Research Grants — A grant in an amount of up to $1,000 was approved for completion of a book by Wilson T. Sowder, M.D. The book is titled, "Florida's Health Under 11 Governors — The Ins and Outs of It."

The Foundation agreed to a letter request from E. Charlton Prather, M.D., of DHRS for implementation of a research project entitled, "Program Inventory and Expenditure Summary of the Association of State and Territorial Health Officials" to be carried out under the current letter agreement the Foundation has with the DHRS.

FMA Auxiliary — The Auxiliary continues its fine efforts to raise funds through various projects for the FMF.

In September 1977, the St. Augustine Preservation Board closed the portion of the tour of historic sites, which included the St. Augustine Spanish Hospital, where artifacts in the medical museum were located. The closing was due to a lack of funds with which to maintain the building in which the museum was housed.

The Auxiliary has been successful in reaching agreement with the Museum of Florida History, Tallahassee, to accept custody of the artifacts and display them to the public.

The Auxiliary is maintaining liaison with the Florida Museum in a program to encourage physicians to donate items to the museum.

FMF Medical Education Committee is a relatively new entity, but already it has had a positive impact upon the provision of quality continuing medical education in Florida. In the summer of 1977, the American Medical Association accredited the committee for continuing medical education on a provisional basis for one year. This action entitled the committee to join with other organizations as an "accredited co-sponsor" of CME and to certify that qualified offerings meet the criteria for AMA Category I Credit.

To date the committee has agreed to co-sponsor seven CME activities and has certified them as meeting the criteria for a total of 101 hours of Category 1 Credit. These include the Scientific Program for the 104th Annual Meeting of the Florida Medical Association, which was certified for 20 hours of Category 1 Credit.

Generally, the committee offers its expertise and co-sponsorship services on a statewide basis, except in Sarasota and Dade counties, where the county medical societies also are accredited for CME. Under a committee policy, applications for co-sponsorship from Dade and Sarasota are referred to the county medical society.

Another major project of the committee has been to compile a registry of FMA members who are willing to present scientific programs to county medical societies and hospital medical staffs. The committee feels the availability of this information will help meet the needs of the smaller hospital staffs and county societies, some of which have called upon the Florida Medical Association and the Foundation committee for program advice.

In carrying out its functions, the committee has worked in tandem with the Committee on Continuing Medical Education of the FMA. Three physicians serve on both committees, and both exchange minutes and reports on their activities.

Chaired by Dr. Robert H. Threlkel of Jacksonville, the FMF committee is composed exclusively of physicians who have had an involvement in and a dedication to top quality continuing medical education.

Florida Physicians Association

The motion of the Reference Committee that the Report of the Florida Physicians Association be adopted carried.

Florida Physicians Association

David T. Overbey, M.D., President

The 1977 Annual Report of the Florida Physicians Association, Inc., that follows will summarize its activities since the last Annual Meeting of the Florida Medical Association held in May of 1977. During this period of time the Association has maintained its organization and conducted its activities pursuant to the original intent for which it was organized. During the last year the Executive Committee of the FPA has consisted of David Overbey Jr., M.D., President; John A. Dyal Jr., M.D., Vice President; Warren M. Barret, M.D., Treasurer; H. Jones Jr., M.D., Secretary; James T. Cook, M.D., Immediate Past President. Other members of the Executive Committee are Charles J. Kahn, M.D., and O. William Davenport, M.D., who are FMA Representatives.

1. **Bylaws Amendment** — At the last Annual Meeting of the Florida Physicians Association, the Executive Committee recommended, and the Board of Directors adopted, a Bylaw amendment that will allow the Immediate Past President to be a member of the Executive Committee of the Florida Physicians Association. It is felt that this will add continuity, and allow a Past President to continue to provide advice and counsel to the governing body.

2. **Membership** — During the past year the membership of the Florida Physicians Association, as of December 31, 1977, was 1,217 members. The staff of the Florida Physicians Association has attempted to provide county medical societies with necessary information to its membership in order to explain the purpose and intent of the Florida Physicians Association.

3. **Annual Meeting** — The Florida Physicians Association will conduct an Executive Committee meeting, Board of Directors meeting, and an Annual Membership meeting, in conjunction with the Florida Medical Association Annual Meeting, in May of 1978.

Judicial Council

The Reference Committee considered the report of the Judicial Council. It was noted that this is the last year Dr. John J. Cheleden would serve on this Council. The Reference Committee acknowledged Dr. Cheleden's long and untiring service and tremendous contributions to the Judicial Council.

The motion of the Reference Committee that the Report of the Judicial Council be adopted as printed in the handbook carried.

Judicial Council

William W. Thompson, M.D., Chairman

The 1978 Annual Report of the Judicial Council will summarize the major areas of activity that occupied the Council's time and energy since the last Annual Meeting of the Florida Medical Association, held in May of 1977. The Council's duties, functions, and composition are specifically prescribed in Chapter 8, Section 3 of the Florida Medical Association's Bylaws. Generally, it is the function of the Judicial Council to direct and supervise the activities of the Association which pertain to questions of medical ethics, dissension, and disputes referred to the Association for investigation and adjudication, complaints by patients against members of the Association, and questions of membership and disciplinary action. The Bylaws of the Florida Medical Association further provide that the component county medical society shall be the basic unit for censuring, suspending, or otherwise disciplining its members. Any member subject to such action has the right to appeal to the Judicial Council, in the manner prescribed by the Bylaws. Since the last Annual Report of your Judicial Council, your Chairman has reported to the Board of Governors up-to-date summations and recommendations relative to the major areas of Council concern. Since the last Annual Meeting the Council has met on the following occasions: May 4, 1977; July 9, 1977; September 10, 1977; January 21, 1978. In addition to these regularly scheduled meetings, a special meeting of the Council was held on February 24, 1978. The membership of the Council has been as follows: William W. Thompson, M.D., Chairman; John J. Cheleden, M.D., Vice Chairman; James A. Winslow Jr., M.D., Chairman, Membership & Discipline Committee; Vincent P. Corso, M.D.; and Joseph H. Davis, M.D. The Council has been staffed by Mr. John Thrasher, FMA Legal Counsel.

The Council's activities are summarized under the appropriate headings as follows:

1. **Dissension in Component Medical Societies**. During the past year, the Council has become increasingly concerned about the amount of time and energy that is being expended by certain county medical societies, and this Council, over matters of internal strife and bickering. It is apparent from the point of view of your Council, that many of the critical issues facing organized medicine today are being ignored by certain elements of our membership because of preoccupation with internal matters that have arisen due to either personality conflicts or economic self-interest. Regardless of the motive causing these problems, it is the feeling of your Council that such activity, where it exists, should be laid to rest and that the membership of this Association should join together in concert to address the many threatening and pervasive issues that are facing the private practice of medicine. It is the feeling of this Council, that while we are willing to work with any component medical society to achieve harmony among its membership, we will not allow a county medical society that has become impotent because of internal problems to thwart the overall objectives of this Association. Accordingly, it will be the continuing position of this Council to closely monitor situations that go beyond individual disciplinary matters wherein the entire membership has become embroiled to the extent that the effectiveness of the society is impaired. In these kinds of situations, the Council intends to recommend to the Board of Governors necessary action to restore an impaired county medical society, so that it may fulfill its role as a component society of the Florida Medical Association.

2. **The Florida Medical Association's Yellow Page Listing Directory Policy**. At the conclusion of the 1977 Annual Meeting, the House of Delegates in one of its actions requested that the Judicial Council consider all aspects of the present policy on listing in the yellow pages, with specific attention directed to the number of specialty listings a physician is allowed to utilize, and the need for additional specialty listings. The Council considered this matter and heard from several members of the Association who appeared on behalf of the Florida Society of Otolaryngology. The Council further discussed the recent Supreme Court of the United States decision, regarding attorney advertising and further considered the current ongoing hearing by the Federal Trade Commission against the American Medical Association regarding certain ethical principles of the AMA. It was the feeling of the Council that not only had the current policy not had sufficient time to be implemented throughout the State, in order to evaluate its effectiveness, but that given the current unsettled situation regarding professional advertising, in both the courts and federal agencies, that it would serve no useful purpose for the Council to recommend changes in the policy at this time. Accordingly, the Council recommended to the Board of Governors that the policy, which was originally adopted by the House of Delegates in May of 1974, and amended subsequently in January 1976 and May 1977, not be changed at the present time. There have been several specific opinions rendered by the Judicial Council in regard to interpretations of the policy, which will follow in this report.

3. **Liaison with the Board of Medical Examiners**. During the past year the Council has maintained a close liaison with the Florida State Board of Medical Examiners. During the course of the Council's meeting on July 9, 1977, the Council temporarily adjourned its meeting to join, in progress, the meeting of the Board of Medical Examiners. The Council has found these meetings with the Board to be highly productive and informative in furthering the mutual goals of both organizations. As a result of the Council's review of the situation in Monroe County, the Council recommended to the Board of Governors, that the Board officially notify the State Board of Medical Examiners of the following proposed guidelines regarding deputization of Association members for the conduct of investigation under the jurisdiction of the State Board of Medical Examiners. These guidelines are as follows: A) That the State Board of Medical Examiners not deputize a member of the Florida Medical Association, unless specific guidelines for responsibilities and authorities are provided to the deputy at the time of his appointment. B) That there be careful and deliberate screening of any proposed deputy appointment. C) That there be regular monitoring and control of the deputy in matters relating to work product and methods of investigation. D) That adequate support personnel, including Board of Medical Examiner investigators and legal counsel be provided as needed to individuals appointed as deputies of the Board. It is this Council's understanding that the Board accepted these recommendations, and will utilize them in respect to future appointments. It is the feeling of your Council that the Board of Medical Examiners has attempted in good faith to carry out its responsibilities. However, because of the lack of adequate legal staff and investigatory staff, the ability of the State Board of Medical Examiners to efficiently carry out its statutory mandate has been diminished. Accordingly, this Council has recommended to the Board

of Governors that the Florida Medical Association take whatever action is necessary to insure that the State Board of Medical Examiners is adequately funded and staffed, to meet its statutory requirements.

4. **Proposed Washington County Medical Society**. The Council has considered the proposed Charter and Bylaws from the Washington County Medical Society, and has found those Bylaws are in accordance with the requirements of the Florida Medical Association. Additionally, the proposed County Medical Society possesses the requisite number of initial members to constitute a component medical society of the Florida Medical Association. Accordingly, your Council has recommended to the House of Delegates that the Washington County Medical Society be chartered as a component County Medical Society of the Florida Medical Association.

5. **Grievances**. During the past year your Council has continued to handle routine grievances that have been presented to it, pursuant to the Bylaws of this Association. The Council maintained its procedure of allowing the county medical societies to resolve these local grievances and report their findings to the individual directly, and to this Council. The Council, of course, pursuant to the Bylaws of the Florida Medical Association, retains the right to withdraw these grievances from the local society if they are not acted upon in a reasonable time. Additionally, an individual may appeal a decision of a local county medical society grievance committee to the Council. This system seems to work efficiently, and this Council encourages each county medical society to process and finalize decisions on grievances in an efficient and expeditious manner. During the course of the year, several county medical societies have requested guidelines as to the fundamental aspects of procedural due-process in grievance proceedings. In reviewing most of these questions, it has been determined that generally speaking, county medical society Bylaws contain the necessary provisions to afford procedural due-process to an individual accused of unethical conduct. It is essential, therefore, that the county medical society not disregard the procedural safeguards enacted in their respective Bylaws or Constitution. These basic criteria can be summarized as follows: A) The charged member should be informed by registered mail of a statement of charges, accompanied by a notice of time and place of the proposed meeting on the charges. B) The charged individual should be afforded the opportunity to appear in person to defend against any of the charges.

6. **Opinions of the Judicial Council**. During the past year the Council has rendered the following opinions:

Opinion 77-1 — The Council opinion of January 24, 1975, is amended to read: A certified Otolaryngologist may not list himself under the heading, Surgery, Plastic unless he is Board certified or Board qualified in, or limits his practice to, plastic surgery.

Opinion 77-2 — A physician's ownership interest in a hospital and service on its utilization committee is ethical so long as such activity in no way exploits the patient.

Opinion 77-3 — A physician may list himself in the yellow pages of a neighborhood directory, provided he maintains an office in the geographical area of the neighborhood directory.

Opinion 77-4 — The FMA Bylaws provide that an Osteopath who has completed an AMA approved internship, and/or residency, is eligible for membership, and the fact that the osteopath may have completed an approved internship, and/or residency, in one specialty, but is currently practicing in another specialty, would not per se disqualify him from membership.

Opinion 77-5 — It would not be unethical for a physician to charge attorneys interest on monies owing for reports, depositions, conferences, court appearances and other similar legal functions since such arrangements constitute a business relationship between the physician and the attorney, and is therefore outside the doctor-patient relationship.

Opinion 77-6 — Pursuant to the policy of the Florida Medical Association governing the listing of members in the telephone directories (white and yellow), adopted by the FMA House of Delegates in May 1974, and amended in January 1976 and May 1977, a physician may list his name, address and telephone number in the yellow pages of any telephone directories that are published primarily for a city, town, or other area in which he maintains a residence or an office, or both.

Opinion 77-7 — When a consultation is required specifically for monitoring a physician in order to determine his capabilities, this consultation should be done without charge to the patient by the consulting physician.

Opinion 77-8 — A listing by a physician in the telephone directory, in a language other than English, would not be in violation of the Florida Medical Association's Yellow Page Directory Listing Policy, provided such listing otherwise followed the policy guidelines.

Opinion 77-9 — In the matter of a physician itemizing his bill, the attending physician should complete without charge, the appropriate simplified health insurance claim form and a similar insurance claim form as a part of his service to the patient, to enable the patient to receive his benefits. Any agreement entered into between the physician and patient, to enable the physician to fairly protect his fee, is not considered unethical.

Supplemental Report Judicial Council

The Reference Committee submitted a substitute recommendation for the recommendation of the Judicial Council.

A substitute motion from the floor to poll the membership of the St. Johns County Medical Society concerning their charter failed to carry.

A substitute motion to revoke the charter effective June 1, 1978, failed to carry.

The substitute motion of the Reference Committee carried.

Supplemental Report Judicial Council

RECOMMENDATION: THAT UNLESS THE ST. JOHNS COUNTY MEDICAL SOCIETY RESOLVES ITS CURRENT DIFFICULTIES TO THE SATISFACTION OF THE JUDICIAL COUNCIL PRIOR TO DECEMBER 31, 1978, ITS CHARTER BE REVOKED EFFECTIVE THAT DATE, AND FURTHER THAT THE DETERMINATION OF WHETHER OR NOT THESE DIFFICULTIES HAVE BEEN SATISFACTORILY RESOLVED SHALL BE LEFT SOLELY TO THE JUDGMENT OF THE JUDICIAL COUNCIL.

The motion of the Reference Committee that the remainder of the Supplemental Report of the Judicial Council be filed carried.

Remarks of the Speaker

The motion of the Reference Committee that the remarks of the Speaker be filed as presented carried. (See page 499.)

President's Address

The Reference Committee had considered the President's Address presented at the First Meeting of the House of Delegates and expressed appreciation for the many efforts which have been made under his direction during the past year on behalf of the Association.

The motion of the Reference Committee that the President's Address be filed as presented carried. (See page 493.)

Special Report

Executive Vice President

The Reference Committee considered the report of the Executive Vice President and recognized the extensive efforts and competent manner in which W. Harold Parham, D.H.A., has handled the numerous federal investigations into the Association's business.

The motion of the Reference Committee that the Special Report of the Executive Vice President be filed and published carried.

Special Report

W. Harold Parham, D.H.A.
Executive Vice President
Florida Medical Association, Inc.

This will just take a couple of minutes, but Dr. Murray feels that it is important the House be advised of what a few of us consider to be harassment by the Federal Government at the present time. I'll give you six examples of what is going on in the Headquarters office today.

In January, we had a special audit of our Florida Medical Foundation by the **Internal Revenue Service** which has been in existence for 26 years and when it was over with, it was obvious that nothing had been done wrong. There was no violation of the Internal Revenue Laws.

As some of you are aware, we are in Federal Court in Tallahassee with charges and investigation by the **Federal Elections Commission**.

The **Federal Trade Commission** has us under subpoena and depositions are being taken at the present time for alleged restraint of trade.

The **Justice Department** is now taking depositions and investigating us for alleged violations of the Sherman Anti-Trust Act.

The **Postal Authority** has just revoked our postal permit after 26 years. We found they had taken similar action in New York and New Jersey. However, we also learned that the Bar Associations were not losing theirs, because they are so called "Educational Associations."

Monday of this week we were advised that the **Internal Revenue Service** is coming back to do a special audit of the FMA and all related organizations for activities during the year 1976.

It has gotten to the point where it appears most of our time and assets of the Association are spent defending our activities. In my opinion, there has been nothing done which is improper. We have a good legal counsel, and good CPA's and I think these investigations are at the point of the ridiculous.

At the appropriate time, there will be recommendations made to the Board of Governors, to go to the Congress of the United States and see if we can't curtail some of the expenditures by the Federal bureaucracy and those bureaucrats who are carrying on harassment.

Special Report

Florida Physicians' Insurance Reciprocal

The Reference Committee considered the oral report on the first year's operation of the Florida Physicians' Insurance Reciprocal presented by Dr. Vernon B. Astler at the first meeting of the House and noted that the report was most informative.

The motion of the Reference Committee that the Special Report on the Florida Physicians' Insurance Reciprocal presented by Dr. Vernon B. Astler be filed and published carried.

Special Report

Florida Physicians' Insurance Reciprocal
Vernon B. Astler, M.D.

The Reciprocal report is in your delegates' packet. The entire story is there. I am just going to highlight one or two items that I think deserve emphasis.

First, I would say that your Reciprocal is alive and it is very healthy. A consolidated report of the finances is included in the packet, and it has been mailed to every member of the Florida Medical Association. It covers the first 25 months of our operation — the Trust and the Reciprocal. Briefly, the total income has been 32 million dollars; the claims paid and reserves have been 10 million dollars; the dividends paid back to subscribers have been 1.8 million dollars; and we've set aside reserves of 10 million dollars, including reserves for death, disability, escrow for reinsurance losses, and surplus, which is required by Florida state law.

I think it's been a success story. The tort reforms sponsored by the Florida Medical Association and supported by your dollars in 1975, '76 and '77 have resulted in a number of favorable influences, the most apparent of which at this time have been the mediation panels and the statute of limitations. These have already worked to our advantage and something over 84-85% of mediation panels are finding in favor of physicians. The statute of limitations, I am told, will affect our negotiations with Lloyd's of London as of next year. M.D. participation has been very rewarding to us. County medical societies have formed committees to help us in our underwriting and given us advice concerning their own members and this has been very helpful. In claims review, consultants hve been used throughout the state, over a hundred in number, and also, the Board of Directors has been most helpful in advising and directing the Reciprocal. I can tell you that PIMCO has the most aggressive management and the lowest overhead of any malpractice insurance plan in America. Our basic feeling is to defend every non-meritorious claim against a physician with the finest law firms that we can hire in this state.

The other corollary of this is that we believe that prompt payment of obvious losses is warranted, and we've done this, settling them early, sometimes with surprising savings to the membership. I think one has to say that Dr. Parham has certainly been the leader in our financial business and economic matters of this Reciprocal. He has worked and toiled for countless hours in our behalf; I don't know how many trips he's made to London, to Washington, to Atlanta and other places; and Jim Walker, who has been our President — I can tell you from personal

experience — has led the medical leadership in this area. He has personally reviewed every claim that's come into our offices. He's investigated them. Where he didn't have the answer, he's sought consultation with many of you out in this audience, and others, to get the right answer to determine the validity of the claim. He's led the charge with proper advice. The commentary would be, in summary, that the Board of Directors, the Attorney-in-Fact, and the PIMCO President are of the opinion that, with some cautious reservations, perhaps the acute crisis of medical malpractice insurance in this state has passed, the drastically inflated costs have probably passed, and the future, they believe, should be more stable. I would certainly offer heartfelt thanks to the members of the Florida Medical Association who have contributed to make this venture a success. Thank you.

Resolution 78-1

Committee on State Board of Medical Examiners

Brevard County Medical Society

The Reference Committee considered Resolution No. 78-1 and observed that the objective of this resolution had already been accomplished by a committee appointed by the President.

The motion of the Reference Committee that Resolution No. 78-1 not be adopted carried.

Resolution 78-2

General Practice Yellow Page Listing

Brevard County Medical Society

The motion of the Reference Committee that Resolution No. 78-2 not be adopted carried.

Resolution 78-8

Public Relations Pamphlet for FMA Members

Brevard County Medical Society

The Reference Committee considered Resolution No. 78-8. Some of the objectives of this resolution are presently being accomplished by the FMA Public Relations Department.

The motion of the Reference Committee that Resolution No. 78-8 be referred to the Board of Governors for consideration by the Public Relations Officer carried.

RESOLUTION 78-8

PR Pamphlet for FMA Members

Brevard County Medical Society

[NOT ADOPTED — Referred to the Board of Governors]

Whereas, Recently there has been a great deal of publ regarding "the accelerating cost of medical care," and,

Whereas, Said publicity is, in many cases untrue or distorted, and, in most cases, detrimental to the image of the Florida physician, and,

Whereas, The 1977 House of Delegates of the Florida Medical Association approved the policy that a part of each member's annual dued be used for the purpose of Public Relations; therefore be it

RESOLVED, That the Florida Medical Association compose a pamphlet explaining the true facts concerning the rising cost of medical care, and, be it

RESOLVED, That these pamphlets be made available to all members of the Florida Medical Association, without charge, to be brought to their patients' attention through display and distribution in their reception rooms, and be it further

RESOLVED, That the tone of these pamphlets be on a positive note, providing useful information as well as explanatory data, somewhat along the lines of the pamphlet recently devised by the State Medical Society of Wisconsin.

Resolution 78-9

State Board of Medical Examiners Deputies

Palm Beach County Medical Society

The Reference Committee considered Resolution No. 78-9, and agreed that additional study was needed before any recommendation could be made.

The motion of the Reference Committee that Resolution No. 78-9 be referred to the Board of Governors carried.

RESOLUTION 78-9

SBME Deputies

Palm Beach County Medical Society

[NOT ADOPTED — Referred to the Board of Governors]

Whereas, Florida physicians recognize the necessity of having an effective and responsive disciplinary procedure, and

Whereas, Existing disciplinary procedures in Florida have in some cases been slow in responding to complaints because the Florida Board of Medical Examiners does not have the funding or the manpower to adequately staff a disciplinary system throughout the State of Florida; and

Whereas, There exists in each Florida County an already existing committee made up of physicians who could be utilized to investigate the conduct and competence of physicians in a responsive and effective manner; therefore be it

RESOLVED, That the Florida Board of Medical Examiners, pursuant to the authority granted to it in Section 458.201 (2) (c), Florida Statutes, deputize those physicians who are the members of each local Florida medical society's disciplinary committee to act for the Board of Medical Examiners in investigation and/or adjudicating the conduct or competence of physicians practicing in each local society's jurisdiction; provided, however, that the local disciplinary committee first comply with the requirements established by the Board of Medical Examiners for such committees and the local society apply to have its disciplinary committee so designated by the Board; and be it further

RESOLVED, That the Board of Medical Examiners establish uniform standards and procedures for the (deputization) and actions of

such local disciplinary committees that desire to be designated as such agents of the Board.

Resolution 78-13
Interim Meeting — FMA House of Delegates
Hillsborough County Medical Association

The Reference Committee considered Resolution No. 78-13, and acknowledged that FMA business mandates a yearly interim meeting, but thought that the time of such meeting should be left to the discretion of the Board of Governors.

The Reference Committee moved an amendment that "in late October or early November" be deleted from the resolution and the words "at a time to be set by the Board of Governors" be substituted and that the amended resolution be adopted.

The motion failed to carry, and Resolution No. 78-13 was not adopted.

Resolution 78-19
Staff Personnel for HSA Monitoring
Dade County Medical Association
and
Board Report on Committee on HSA's
(Deferred during Report of R.C. V)



The Deans of Florida's three medical schools pause with FMA Auxiliary President Mrs. Richard B. Moore, who presented each with a check representing American Medical Association Education and Research Foundation gifts. Left to right: Hollis G. Boren, M.D., Tampa, Dean of the University of South Florida College of Medicine; Mrs. Moore; Emanuel M. Papper, M.D., Miami, Dean of the University of Miami School of Medicine; and William B. Deal, M.D., Gainesville, Dean of the University of Florida College of Medicine.

The Reference Committee moved an amendment to Resolution 78-19.

A motion to amend the Reference Committee's amendment to Resolution 78-19 by adding the word "more" before the word "adequate" carried.

A motion to amend the amendment to the amendment to Resolution 78-19 by adding the words "and county medical society" before the word "staff" carried.

The motion of the Reference Committee that Resolution No. 78-19 be adopted as amended carried.

A motion to consider the Board's Report on Committee on HSA's which had been deferred from the second session of the House carried. A motion to adopt the report of the Committee on HSA's with the insertion of the wording from Resolution 78-19 carried. (See Board Report, page 541.)

RESOLUTION 78-19

Staff Personnel for HSA Monitoring

RESOLVED, That the FMA assign more adequate FMA and county medical society staff to insure effective parallelling of all nine HSA's in Florida.

Resolution 78-21
Change in Code of Medical Ethics
Dade County Medical Association

The motion of the Reference Committee that Resolution 78-21 not be adopted carried.

The Reference Committee reviewed the 1977 financial audits and commended W. Harold Parham, D.H.A, for his able handling of the financial affairs of FMA, Florida Medical Foundation, FLAMEDCO, and Professional Insurance Management Company (PIMCO).

The Chairman thanked each member of the Reference Committee: Eugene Valentine, M.D.; Franklin Pfeiffenberger, M.D.; Brian P. Gibbons, M.D.; John H. Parker, M.D.; and Samuel M. Day, M.D., AMA Delegate Advisor. The Chairman also thanked Mr. John E. Thrasher, FMA Legal Counsel, and Ms. Jan Taylor, Recording Secretary.

The motion of the Reference Committee that the Report of Reference Committee No. III be adopted as a whole as amended carried.

The Speaker resumed the Chair and called for the Report of Reference Committee No. II.

Report of Reference Committee No. II
Public Policy

Dr. Herbert E. Brooks, Chairman, and his committee came forward to present the report of Reference Committee No. II, Public Policy.

Report of the Council on Medical Services

The Reference Committee expressed its gratitude to Dr. J. Russell Forlaw for his years of service as Chairman of the Council on Medical Services and commended the six component committees for their devoted and dedicated efforts throughout the years.

During the deliberations concerning the report of the Committee on School Health, it was brought to the Committee's attention that there was a major problem in the state of unwanted adolescent pregnancies.

The motion of the Reference Committee that this problem be referred to the Board of Governors, for consideration and definite recommendations by the Committee on School Health, and that county medical societies encourage physicians to participate in efforts to resolve this problem, carried.

The Committee noted in the report of the Committee on Sports Medicine that recommendations had been made on several aspects of high school athletics. The Reference Committee pointed out that chiropractors are doing pre-athletic physicals and serving as team physicians in some areas of the state.

The motion of the Reference Committee that this subject be referred to the Board of Governors for immediate action and recommendation by the Committees on Sports Medicine and School Health carried.

The motion of the Reference Committee that the Report of the Council on Medical Services be adopted as printed in the handbook carried.

Council on Medical Services

J. Russell Forlaw, M.D., Chairman

In 1977, the Council on Medical Services was expanded to include the services of the Committee on Sports Medicine. Therefore, the Council now has six committees developing programs for improving the delivery of medical care in Florida. All of these committees have been active; as during the year, the Council forwarded 31 recommendations for consideration by the Board of Governors.

During this reporting period, the Council on Medical Services held two meetings: in Miami on September 18, 1977, and in Tampa, February 26, 1978. The following is a consolidated report of each committee's activities for the year:

The Committee on Rural Health became the Council's most active committee by working on a number of rural health programs. Besides having three formal meetings, representatives of the committee attended several workshops on the delivery of primary care in underserved areas. Also, special briefings were held with the Chairman of the Senate HRS Committee and a legislative proposal has been developed for consideration by the Committee on State Legislation.

In addition, the committee planned and conducted the FMA's



Reference Committee II looked into public policy matters. Left to right: Clarence M. Gilbert, M.D., Orlando; Joseph Harris, M.D., Miami Beach; Herbert E. Brooks, M.D.; Bonifay, Chairman; Ms. Joan Kussmaul, Jacksonville, Recording Secretary; Walter C. Jones, M.D., Coral Gables; and Paul A. Tanner Jr., M.D., Auburndale.

second "Physician Recruitment Conference" for those communities in need of a physician. The conference was held on October 29th in Gainesville and this year's attendance more than doubled the previous conference. Press coverage of this Conference was excellent and special news features were carried in newspapers around the State.

The Rural Health Committee continues to participate in the Florida Committee on Rural Health which represents a number of State organizations.

The Committee on School Health continues to serve as the official State School Health Medical Advisory Committee to the Department of Education and Health Program Office, Department of Health and Rehabilitative Services.

During the past year, three meetings were held and the Committee made recommendations concerning screening school personnel for tuberculosis, the establishment of an FMA Ad Hoc Committee on Nutrition, guidelines for handling students with asthma and the handicapped children program.

Creation of a local school health medical advisory committee in every county is a major goal of the State Committee. Such committees would have a significant impact on school health programs.

The Committee on Public Health reviewed and made recommendations on a number of subjects including proper immunization of children, chlorination of public water supplies, marketing of unpasteurized milk and liaison with home health care agencies.

For a number of years, Doctor William R. Stinger of Miami chaired the Florida Medical Association's Committee on Public Health. His knowledge and reputation as a public health officer is recognized throughout the State. The recent announcement of his death has deeply saddened those of us who had the honor of knowing him. Doctor Stinger's many years of service to the FMA can only be described as invaluable.

The Committee on Drug Abuse held two meetings during this reporting period. Topics for discussion included proper disposal of used syringes and sample drugs, insurance coverage for drug abuse treatment, growing abuse of phencyclidine (P.C.P.) and the AMA's position on modifying marijuana laws.

Recently, the Committee commended the Duval County Medical Society, Jacksonville Area Osteopathic Medical Society and the Jacksonville Pharmaceutical Association for their program to voluntarily remove all amphetamines and methaqualone from the shelves of local pharmacies. The Committee has recommended that all component societies explore the feasibility of a similar program in their own local areas.

The Committee on Emergency Medical Services and Emergency Communications was extremely active this year. Three formal meetings were held with two of them lasting three days. Several special meetings were called to address specific problems. The Committee reviewed and made recommendations concerning funding for EMS communications, advanced life support training courses for physicians, the availability of funding for the implementation of a statewide 911 emergency phone system, assisting communities in obtaining EMS grants and the medical aspects of disaster planning.

During the past year, the Committee was instrumental in the drafting of an amendment to the 1973 EMS Act which requires that all advanced life support providers must have a medical director. This action will assure good medical supervision of advanced life support programs. To help clarify the role of the EMS medical director, the Committee received Board approval for the FMA to sponsor the March 3, 1978, "Conference on the EMS Medical Director and the EMS Law." Approximately 100 physicians and organizational representatives attended this informative meeting.

The Committee on Sports Medicine was assigned as a standing committee of the Council on Medical Services. During the past year, two meetings were held and liaison was established with the "Florida High School Activities Association" and the "Florida Athletic Coaches Association."

Recommendations were made regarding FTE funding for athletics, ambulances being present at high school athletic events, when feasible, developing athletic trainers for middle and high school programs and the establishment of an athletic injury reporting service for Florida.

The Florida Athletic Coaches Association invited Committee representatives to be on the program for their coaches conference on the "Medical Aspects of Sports." Currently, the Committee is planning a similar conference for physicians.

BOARD OF GOVERNORS REPORT
Referrals by the 1977 House of Delegates

Resolution 77-8

High School Sports

The motion of the Reference Committee that the Board's report on Resolution 77-8 (High School Sports) be adopted as printed in the handbook carried. (See Board Report, page 530.)

Board Actions of Major Importance

Board Actions of Major Importance

Emergency Medical Services

The motion of the Reference Committee that the Board action on Emergency Medical Services be adopted as printed in the handbook carried. (See Board Report, page 532.)

Definition of Public Health

The motion of the Reference Committee that the words "groups of individuals" be amended to read "the total community" and that the Board action on the definition of public health and recommendation no. 5 be adopted as amended carried. (See Board Report, page 534.)

Conference on Gerontology

The motion of the Reference Committee that the Board action on the Conference on Gerontology be adopted as printed in the handbook carried. (See Board Report, page 534.)

Florida Psychiatric Society Resolution

The motion of the Reference Committee that the Board action on the Florida Psychiatric Society resolution and recommendation no. 6 be adopted as printed in the handbook carried. (See Board Report, page 534.)

Health Care in Correctional Institutions

The motion of the Reference Committee that the Board action on health care in correctional institutions be adopted as printed in the handbook carried. (See Board Report, page 534.)

FMA Councils and Committees Section

Council on Medical Services

The motion of the Reference Committee that in Recommendation No. 18, to insert the word "Retail" after the word "local" carried.

The motion of the Reference Committee that the Board's report on the Council on Medical Services including recommendations 15, 16, 17 and 18, be adopted as amended carried. (See Board Report, page 539.)

Committee on Allied Health Professions

The motion of the Reference Committee that the Board's report on the Committee on Allied Health Professions be adopted as printed in the handbook carried. (See Board Report, page 540.)

Committee on Voluntary Health Agencies

The motion of the Reference Committee that the Board's report on the Committee on Voluntary Health Agencies be adopted as printed in the handbook carried. (See Board Report, page 541.)

Report of the Committee on Allied Health Professions

The Reference Committee commended Dr. Luis Perez, Chairman, and the members of the Committee on Allied Health Professions for their skillful work throughout the year.

The motion of the Reference Committee that the report of the Committee on Allied Health Professions be adopted as printed in the handbook carried.

Committee on Allied Health Professions

Luis M. Perez, M.D., Chairman

During this past Association year, the Committee on Allied Health Professions held two joint meetings with representatives of the following recognized allied profession organizations:

1. Florida Dental Association
2. American Association of Medical Assistants, Florida State Society
3. Florida Dietetic Association
4. Florida Society of Medical Technologists
5. Florida Nurses Association
6. Florida Association of Dispensing Opticians
7. Florida Pharmaceutical Association
8. Florida Chapter, American Physical Therapy Association
9. Florida Podiatry Association
10. Florida Society of Radiologic Technologists
11. Florida Veterinary Medical Association
12. Florida Society for Respiratory Therapy
13. Florida Academy of Physician's Assistants

In addition to these groups, representatives from the Florida Association of EMT's, Florida Occupational Therapy Association and Florida Cardiopulmonary Association attended the joint meetings and indicated their intentions to submit applications for formal FMA recognition.

For two years, the Committee has monitored the writing of the rules and regulations for the Nurse Practice Act of 1975. Public hearings have been held around the State and the FMA presented testimony at each of these meetings. In July 1977, the Board of Nursing promulgated rules which will govern licensure, training and educational requirements. However, the section on additional functions for advanced nurse practitioners has not been published but is expected soon.

Over the past year, a number of allied health professions have presented resolutions to the Committee in support of the FMA's position concerning the establishment of a separate Department of Health.

Report of the Committee on Voluntary Health Agencies

The Reference Committee expressed its appreciation to Dr. Robert C. Palmer for his fine efforts as Chairman of the Committee on Voluntary Health Agencies.

The motion of the Reference Committee that the report of the Committee on Voluntary Health Agencies be adopted as printed in the handbook carried.

Committee on Voluntary Health Agencies

Robert C. Palmer Jr., M.D., Chairman

During the past Association year, the Committee on Voluntary Health Agencies held two meetings in Tampa: on September 16, 1977, and January 29, 1978. Representatives of the various VHA's attended these meetings and reported on the activities of their organizations.

Fourteen voluntary health agencies received FMA recognition during the 1977-78 Association year:

1. Florida Chapter, Arthritis Foundation
2. Florida Division, Leukemia Society of America
3. American Heart Association, Florida Affiliate
4. Florida Division, American Cancer Society, Inc.
5. Florida Epilepsy Foundation, Inc.
6. Florida Coordinating Council of the National Kidney Foundation
7. Florida Association for Retarded Citizens
8. The National Foundation, March of Dimes
9. Florida Lung Association
10. United Cerebral Palsy of Florida, Inc.
11. Easter Seal Society for Crippled Children and Adults of Florida, Inc.
12. National Multiple Sclerosis Society, Southeast Region
13. Mental Health Association of Florida, Inc.
14. Florida Society for the Prevention of Blindness, Inc.

At each of the above meetings, the Committee stressed the need for medical input in VHA programs and pointed out the recognition program requirement that there be adequate physician representation on the VHA board of directors. Last year several VHA's received recognition with the stipulation that the medical representation on their board be increased.

Presently, the Committee is completing the review of applications for the 1978-79 recognition program. Close attention is being given to programs for patient services and professional education.

It is anticipated that during the 1978 session of the State Legislature the Secretary of State will propose a new Charitable Solicitation Act which will contain more flexible provisions regarding agency expenditures for administration. This type legislation will require a great deal of study.

Resolution 78-14

Blood Banking

Orange County Medical Society

The Reference Committee considered Resolution 78-14, Blood Banking, and thanked Dr. Sanford A. Mullen, of Jacksonville, and Dr. Oscar Freeman, of Orlando, for their informative testimony on the subject of blood banking.

After review, the Reference Committee felt that certain amendments to the Resolution were in order.

The motion of the Reference Committee that the word "pluralistic" be changed to "dual"; and that the words "consider withdrawal of" be changed to "re-evaluate the status of its" carried.

The motion of the Reference Committee that Resolution 78-14 be adopted as amended carried.

RESOLUTION 78-14

Blood Banking

RESOLVED, That the Florida Medical Association reaffirm support of the AMA policy favoring the dual approach to blood collection encouraging blood banks to use incentives proven successful in recruiting volunteer donors in their jurisdiction; and be it further

RESOLVED, That the FMA urge the American Blood Commission to revise its 1977 action advocating a singular approach to blood collection in favor of a dual approach; and be it further

RESOLVED: That, if the American Blood Commission continues its current stand of a singular approach, FMA request AMA at its June 1978 meeting to re-evaluate the status of its membership in the American Blood Commission.

The Chairman of the Reference Committee stated that it was an honor to have served as Chairman of Reference Committee II in addressing the issues of FMA Public Policy. He also expressed his sincere appreciation to Doctors Paul Tanner, Clarence M. Gilbert, Walter C. Jones and Joseph Harris, for rendering their knowledge and expertise as members of the Committee.

The Reference Committee expressed its appreciation to all of those members of the FMA who appeared and presented testimony on all of the issues concerning FMA public policy.

A special thanks was conveyed to Dr. Richard G. Connar, Hillsborough County, who served as the AMA Delegate representative at the meeting of the Reference Committee.

The Reference Committee also thanked Mrs. Joan Kussmaul, Recording Secretary, and Mr. Robert J. Harvey, FMA Staff, for their hard work and many hours of assistance in the preparation of the report.

The Speaker recognized Dr. Guy T. Selander, Past President of the Duval County Medical Society, for his outstanding efforts on Duval County Medical Society's program for amphetamine control.

The motion of the Reference Committee that the report of Reference Committee No. II be adopted as a whole as amended carried.



FMA Auxiliary Annual Meeting Highlights

1, Mrs. Richard B. Moore, President, addresses the FMA House of Delegates; 2, Mrs. Mary Sharpe, R.N., Director of HOSPICE, was one of the Auxiliary's guest speakers; 3, Mrs. M. Bruce Martin of Huntington, W.Va., President of the Southern Medical Association Auxiliary, installs FMA Auxiliary officers; 4, Mrs. Moore and Mrs. C. Brooks Henderson present the Peggy Wilcox Award to Mrs. Eugene Hanson; 5, Mrs. Moore (left) presents the gavel to the incoming President, Mrs. Thomas B. Thames; 6, Mrs. Moore (left) introduces her husband, Dr. Moore, as Mrs. Francis Coleman and Mrs. Martin look on; 7, the new President, Mrs. Thames; 8, Mrs. Moore with Hollis G. Boren, M.D. (left), Dean of the University of South Florida College of Medicine; E. M. Papper, M.D., Dean of the University of Miami School of Medicine; and William B. Deal, M.D., Dean of the University of Florida College of Medicine; 9, Mrs. B. D. Epstein presents Mrs. Daniel B. Nunn, President of the Auxiliary to the Duval County Medical Society, a certificate for membership gains.

Report of Reference Committee No. I Health and Education

The members of Reference Committee No. 1 came forward to present the report of Reference Committee No. 1, Health and Education. Dr. David Hubbell presented the report for the Chairman, Dr. Thomas D. Bartley, who had to leave the meeting unexpectedly.

Council on Scientific Activities

The motion of the Reference Committee that Dr. Henry M. Yonge, Vice Chairman of the Committee on Continuing Medical Education, in charge of the 104th Annual Meeting Scientific Program, be commended for the outstanding scientific program developed by the specialty groups under his supervision carried.

The motion of the Reference Committee that the report of the Council on Scientific Activities be adopted as printed in the handbook carried.

Council on Scientific Activities

Yank D. Coble Jr., M.D., Chairman

Since the last Annual Meeting of the Florida Medical Association, the Council on Scientific Activities has met in Tampa on September 23, 1977, and February 25, 1978. This Annual Report of activities is arranged under appropriate committee headings or "Other Business." Several recommendations of the Council and its Committees were previously submitted to, and acted upon, by the Executive Committee and the Board of Governors. They appear in the report of the latter body.

Committee on Continuing Medical Education

The Committee on Continuing Medical Education, chaired by Dr. O. Frank Agee, met on May 6, 1977 at Hollywood; on August 19, 1977, at Tampa; on December 9, 1977, at Miami Beach; and on February 24, 1978, at Tampa. A major effort this past year has been a visitation of county medical societies and hospitals to identify those that might qualify for continuing medical education accreditation. It has maintained and strengthened communication with the membership in regard to CME programs. Its goal is to promote the availability of high quality, low cost accredited CME throughout the State, retaining local control and responsibility.

1. **Annual Meeting Scientific Program:** Dr. Henry M. Yonge, Vice Chairman of the CME Committee in charge of the Annual Meeting Scientific Program, has developed and coordinated another outstanding scientific program for the 104th Annual Meeting. Thirty-three of FMA's 37 recognized specialty groups are participating in the scientific program as co-sponsors of 34 sections. For the third consecutive year the program will feature four one-hour segments of "Dialogue" plus programmed instruction using the AutoTutor.® Twenty-eight scientific and educational exhibits will be on display in the Convention Hall of the Diplomat Hotel. For the first time the scientific program is being co-sponsored by the Medical Education Committee of the Florida Medical Foundation, which has certified the entire program as meeting the criteria for 20 hours of American Medical Association Category I Credit. The program also is acceptable for 20 hours of Mandatory Credit under the FMA's CME program for members.

2. **Accreditation:** During the year, the CME Committee undertook a statewide canvass of county medical societies, hospitals and other organizations which have the potential to be accredited for continuing medical education by the Liaison Committee on Continuing



Reference Committee I studied issues in health and education that were submitted to the House of Delegates. Left to right: David S. Hubbell, M.D., St. Petersburg; Thomas D. Bartley, M.D., Gainesville, Chairman; Vincent P. Corso, M.D., Miami; Karl R. Rolls, M.D., Sarasota; and Ms. Cynthia Kelly, Jacksonville, Recording Secretary.

Medical Education (formerly a function of the American Medical Association). Several counties have been visited by members of the Committee, and it is expected that some applications for accreditation will be forthcoming.

The goal of the CME Committee is a network of accredited agencies strategically located so that no Florida physician will have to travel more than one-half hour to attend Category I CME activities.

Special note should be made of the Florida Medical Foundation Education Committee. This Committee was established on the recommendation of the CME Committee to provide an institution within organized medicine qualified to sponsor and co-sponsor AMA Category I Credit CME activities and to increase the availability of high quality, economical CME courses throughout the State (See No. 1 under "Other Business").

During the past year the following hospitals and organizations have been accredited or reaccredited as indicated:

a. Medical Education Committee of the Florida Medical Foundation — Accredited provisionally for one year.
b. Sarasota County Medical Society — Granted regular reaccreditation for three years.
c. Mercy Hospital, Miami — Accredited provisionally for one year.
d. South Florida Psychiatric Society — Granted regular reaccreditation for two years.
e. Halifax Hospital Medical Center, Daytona Beach — On December 9, 1977, CME Committee recommended to the Liaison Committee on Continuing Medical Education that Halifax be granted regular reaccreditation for three years.
f. Cedars of Lebanon Health Care Center, Miami — On February 24, 1978, CME Committee formally voted to recommend that Cedars be granted regular reaccreditation for three years.
g. Florida Academy of Family Physicians — On February 24, 1978, CME Committee formally voted to recommend that the Academy be granted regular reaccreditation for three years.
h. Tallahassee Memorial Hospital — On February 24, 1978, CME Committee voted to recommend that TMH be granted regular reaccreditation for three years.

3. **Individual CME Program for Members:** CME Cycle 2 under the FMA program of CME for members,ended on December 31, 1977. Cycle 3 will terminate on December 31, 1978. Thereafter county medical societies are to begin reporting to the FMA the names of members who fail to meet the requirements.

The CME Committee has added a fourth pathway toward fulfilling the CME requirements — board certification. Certification or recertification in a primary specialty or subspecialty by any of the 22 approved specialty boards is now accepted as an alternate means of meeting the CME requirements in full for one three-year cycle. Other methods of meeting the triennial requirement include: (1) Presentation of a valid Physician's Recognition Award (PRA) certificate, or the CME certificate of other organizations that may be used to receive a PRA; (2) Election or re-election to membership in the Florida Academy of Family Physicians on the basis of acceptable study reports; and (3) hour-for-hour reporting of 150 hours of CME every three years, including at least 60 hours of Mandatory Credit.

4. **CME Exemptions:** From the beginning of the CME program in 1974, Life Members of the Association have been exempted. Also, it has been the policy to reduce the number of required hours for physicians in parttime practice. However, the Board of Governors, in October 1977, adopted the position "that all Florida Medical Association members engaged in the practice of medicine be subject to the full requirements of the FMA CME program, and that appeals for exemptions and extensions be considered on an individual basis." The CME Committee subsequently recommended to the Board that the policy be implemented as of January 1, 1979.

5. **Individual Program Approval:** The Subcommittee on Program Approval processed an estimated 300 individual applications for FMA Mandatory Credit for CME activities during the year. Under a revised procedure adopted by the CME Committee early in 1977, these applications are channeled first through the local county medical societies for evaluation prior to a decision by the FMA Subcommittee.

6. **Computerization of CME Records:** Resolution 77-19 adopted by the House of Delegates in May 1977 directs the CME Committee to survey methods used by the AMA and other national groups to maintain continuing medical education records, and directs FMA to develop "as soon as practical and feasible" a centralized computer system for maintaining CME records of FMA members. At the present time and since the beginning of the CME Program, individual CME records have been collected, evaluated and maintained by the county medical societies. Although this system provides maximal local control of CME programs of individual FMA members, it does result in an administrative burden to county societies. The CME Committee has investigated the systems of the American Medical Association, the American Academy of Family Physicians, the American Urological Association, the American College of Obstetricians and Gynecologists, the Pennsylvania Medical Society, and others. The Committee has outlined a plan whereby the computerized program would be phased in one cycle at a time beginning January 1, 1979, using the computer shared by FMA and the Professional Insurance Management Company (PIMCO). The CME Committee's report on this matter has been reviewed by the Council on Scientific Activities and passed on to the Board of Governors.

7. **Specialty Society Criteria:** FMA's 37 recognized specialty groups were invited to resubmit CME criteria based on revised guidelines adopted by the Committee. Specifically, the societies were asked if they would wish to require that a specified number of hours of Mandatory Credit be earned by their members in their specialty fields. Twenty-four specialty groups responded, all but three of which stated they did not wish to amend the FMA CME criteria.

8. **Liaison Committee on Continuing Medical Education (LCCME):** On July 1, 1977, the LCCME assumed from the American Medical Association full responsibility for accrediting CME programs throughout the United States. LCCME has elected to maintain the same agreements for local survey work that the AMA had with state medical associations, including the FMA through its Committee on Continuing Medical Education. LCCME is a 30-member body with the following representation: AMA (5); American Board of Medical Specialties (5); American Hospital Association (5); Association for Hospital Medical Education (2); Association of American Medical Colleges (4); Council of Medical Specialty Societies (6); Federation of State Medical Boards (1); Federal Government (1); and the public (1).

Several state medical associations have expressed concern over the dilution of the AMA's authority in accreditation matters inasmuch as it has only four voting representatives and one non-voting seat on the LCCME. This concern has given rise to the formation of a National Council of State Chairmen of Continuing Medical Education, which had an organizational meeting in Chicago on December 3, 1977. The Council's principal goal is greater representation of the practicing physician on the LCCME. A representative of the CME Committee, Dr. Henry M. Yonge, attended the organizational meeting, and based on his report the Committee on Continuing Medical Education and the Council on Scientific Activities have recommended to the Board of Governors that FMA consider participating as a member of the Council of State Chairmen of Continuing Medical Education.

9. **Continuing Osteopathic Education:** During the summer of 1977 the Committee on CME received a request that FMA co-sponsor a scientific meeting sponsored by District 11, Florida Osteopathic Medical Association, in Lee County, December 1-4, 1977. Since it is

beyond the authority of the CME Committee to commit the FMA to cosponsorship of any CME activity, the request was forwarded to the Board of Governors. As a result of consultations involving the Board of Governors, the Chairmen of the CME Committee and of the Council on Scientific Activities, and officials of the Lee County Medical Society, it was decided not to co-sponsor this program but to audit it in order to obtain information that would be useful in evaluating future requests of this nature. Dr. Calvin W. Martin of the CME Committee attended the FOMA meeting. As a result of Dr. Martin's observations, the CME Committee tentatively adopted, subject to approval of the Board of Governors, a procedure for processing and acting upon requests from osteopathic organizations for FMA co-sponsorship and FMA CME credit.

10. **Representation at Meetings:** In addition to the meetings described in Items No. 8 and 9 above, the Committee was represented by Dr. Maurice H. Laszlo at the 74th Congress on Medical Education in Chicago, February 3-5, 1978; by Dr. Pat B. Unger at a Seminar on Community Hospital CME sponsored by the Dade County Medical Association in Miami, November 17, 1977; and by Dr. O. Frank Agee at a meeting of the AMA Council on Medical Education in Tampa, March 11, 1978.

Committee on Scientific Publications

Under the editorship of Dr. Gerold L. Schiebler for the third consecutive year, the Committee on Scientific Publications and **The Journal of the Florida Medical Association** completed another year of significant progress. Important milestones included the production of two outstanding special issues, the addition of three JFMA editors from the ranks of our three medical school student bodies, creation of an awards contest for county medical society bulletins, and most importantly, enlarging even further the broad FMA membership participation in producing a very high quality journal.

1. **Special Issues:** A Special Issue on Cuban Medicine, published as the August 1977 Historical Issue, has become one of the most distinctive and popular issues of JFMA in recent years. Guest Editor Enrique Huertas, M.D., of Miami, and JFMA Historical Editor William M. Straight, M.D., also of Miami, drew upon the considerable talents of a number of Cuban-American physicians in producing this history of medicine in Cuba and the exodus of Cuban physicians from the Communist regime to the United States.

In March 1978 another special issue, Adverse Reactions to Plants in Florida, containing 67 full-color illustrations was published. Guest Editor Laudie McHenry, M.D., was assisted in this project by Philip Blank, M.D. Generous funding by several groups and individuals made it possible to provide all Florida medical students and family practice and pediatric residents complimentary copies.

In May, JFMA will publish the second Special Auxiliary Issue. This will be followed in September 1978 by a Special Issue on Otolaryngology, in cooperation with the Florida Society of Otolaryngology; and in January 1979 by a Special Issue on Orthopedic Surgery, in cooperation with the Florida Orthopedic Society.

2. **Awards:** The Special Issue on Neurological Surgery, produced in November 1976, was awarded first place in the special issues category of the 1977 Magazine Awards Contest of the Florida Magazine Association. JFMA was unsuccessful in the 1977 Sandoz Medical Journalism Awards Contest, but has entered three issues in the 1978 contest.

3. **Medical Student Editors:** In 1977, the Committee on Scientific Publications became the first FMA Committee to have medical student membership. Each of Florida's three medical schools has a student representative recommended by the dean. Under an annual rotational system recommended by the Committee on Medical Education and approved by the Board of Governors, one student will serve as an Assistant Editor of JFMA and two others will serve as consulting editors. The first medical student Assistant Editor is Mr. Alan Zablocki of the University of South Florida College of Medicine. First student consulting editors are Mr. Jerrold Van Dyke of the University of Florida and Mr. Richard Snyder of the University of Miami.

4. **JFMA Awards Contest for County Medical Society Bulletins:** In an effort to foster additional interest in medical journalism at the local level, the First Annual Journal of the Florida Medical Association Awards Contest for County Medical Society Bulletins was established. There are five categories of competition: (1) General Excellence; (2) Most Improved Bulletin; (3) Best Editorial; (4) Best Regular Feature; and (5) Special Recognition. Forty entries were submitted by eight publications and were judged in March. Awards will be announced and presented at the Second Session of the House of Delegates during the 104th Annual FMA Meeting.

5. **Readership Survey:** The February 1978 issue of JFMA carried the publication's first readership survey in several years. The Committee hopes that the survey will provide information useful in further adapting the JFMA to the specific needs of Florida physicians.

6. **New Features:** JFMA currently is running a series of editorials addressing the various program priorities of the Florida Medical Association as established by the Board of Governors in June 1977. A Medical Economics Page made its debut recently and will be repeated from time to time. Rural Health and Medical Services Pages also are scheduled for introduction. A summary of actions of the FMA Board of Governors now is published in JFMA in the month following each Board meeting.

7. **County Medical Society Visitation:** The Committee's program of having one of its members visit each county medical society once over a three-year period continued. The purpose of these visits is to describe JFMA's plans for the future, invite comment, and encourage even greater physician participation in the magazine. In the past three years literally hundreds of Florida physicians have written or reviewed manuscripts submitted for publication or have assisted the Committee in various other ways.

8. **Typography and Design:** A gradual transition to a new type face began in the March issue and will be completed in the summer. New logotypes are being designed to signal regular JFMA features. When these changes are effected, the JFMA should have a more attractive, inviting appearance.

9. **Meeting with Bulletin Editors and Consulting Editors:** Following a custom initiated two years ago, the Committee met twice on February 3, at Lake Buena Vista, first with the county medical society bulletin editors, then with the Board of Consulting Editors. The Committee has found these meetings to provide a useful forum for suggestions and other information.

10. **Copyright Law:** The 1976 Copyright Law, the first major updating and overhaul of the law of copyright, became effective in January 1978 and has had some impact on JFMA. The new law provides copyright protection to a work from the moment of its creation, i.e., at the moment it is first fixed on paper. On the advice of legal counsel, this important conceptual change makes it necessary for JFMA to obtain a transfer of copyright from each and every editorial contributor at the time the contribution is made.

Committee on Medical Education

Dr. J. Donald Wargo, Chairman of the Committee on Medical Education for the third straight year, held Committee meetings in Tampa on September 18, 1977, and in Orlando on January 22, 1978. Deans of the three medical schools and the chairmen of the deans' medical advisory committees comprise this important committee.

1. **Medical Student Aid:** At its most recent meeting, the Committee was made aware of a potential crisis in the area of financial

aid availability for medical students. The problem is one of rising costs of medical education accompanied by a relative decline in student aid funds. Accentuating the problem is the reluctance of banks to commit funds for long-term student loans because of the incidence of default. Increasingly, students are incurring service obligations by turning to National Health Service Corps and other federal scholarship programs. Because of the deferment rules under these programs, the residency selection process also is disturbed. The Committee has been in touch with the three medical schools regarding their specific situations and has recommended to the Council on Scientific Activities that the FMA express its concern about the financial aid situation to the Florida Legislature and to the State's Congressional Delegation.

2. **Funding for Geriatrics Programs at Medical Schools:** Rep. George Sheldon of Tampa has requested through the FMA Capital Office that FMA assist in the development of an appropriation to fund training in geriatrics in the curricula of Florida's three medical schools. Two of the three medical school deans have indicated that geriatrics is adequately covered in the medicine and psychiatry programs, and that categorical funding is undesirable. The Committee concurred in these assessments.

3. **Health Professions Assistance Act of 1976**: The Committee has been monitoring and assessing the implications of the Health Professions Assistance Act of 1976 and important amendments that were enacted late in 1977. The original law required medical schools—as a condition of continuing to receive capitation funds — to admit a certain number of U.S. citizens presently attending foreign medical schools. Further, medical schools were prohibited from imposing scholastic admission standards to deny admission. Most of the objectionable features were removed by the 1977 amendments. However, several medical schools indicated they would give up capitation rather than admit the American students at foreign schools under present standards. Thus, Congress may investigate further whether capitation for medical schools is desirable or necessary.

4. **Caribbean Medical Schools**: The Committee has been advised of the development of several medical schools in the Caribbean area. It is believed that this situation may have a future impact on the transfer of students to United States schools.

5. **Chandler A. Stetson, M.D.:** The Committee was shocked and saddened by the untimely death of Chandler A. Stetson, M.D., of Gainesville, on May 25, 1977. The late Vice President for Health Affairs and Dean of the College of Medicine at the University of Florida was a member of the Committee on Medical Education, which he served faithfully and productively in spite of the many other demands upon his time. Acting Dean William B. Deal, M.D., has carried on uninterrupted Dr. Stetson's work with the Committee.

Other Business

1. **Florida Medical Foundation Committee on Medical Education:** Although the FMF Committee is not organizationally a part of the Council on Scientific Activities, its work is deserving of mention in this report. In the summer of 1977, the Committee was accredited for continuing medical education provisionally for one year. At its meeting on September 24, 1977, the Committee developed rules and procedures for extending accredited co-sponsorship to other organizations. These and appropriate application forms were sent to all county medical societies, hospitals, specialty groups and other organizations offering CME in Florida. To date the Committee has become an accredited co-sponsor of programs offering more than 100 hours of AMA Category I Credit to Florida physicians.

Responding to a request by the FMA CME Committee, the FMF has begun to compile a roster of Florida physicians who are available to present scientific programs to hospital staffs and county medical societies. This resource should be of value to small county medical societies and hospital medical staffs, many of which have called upon the FMA CME Committee for assistance in arranging scientific programs.

The Committee, chaired by Robert H. Threlkel, M.D., works closely with the FMA Committee on CME. Three members of the FMA Committee serve also on the Foundation Committee, and the two groups exchange meeting minutes and reports at their respective meetings.

2. **Adolescent Medicine:** The Council on Scientific Activities has given conceptual approval to adolescent training programs at the medical school level. The Council's consideration of this matter was occasioned by an application from the University of Florida to the Federal Bureau of Community Health Services for establishment of a "Program of Interdisciplinary Training for Adolescent Health." While the application was not approved by the Bureau, the Council believes the subject is of importance and warrants an in-depth study by the Committee on Medical Education as to how the matter of adolescent health might be addressed.

3. **Committee on Research:** Each year the Council on Scientific Activities serves as the Committee on Research to evaluate and make recommendations with regard to Florida Medical Foundation research grant applications. However, funds were not sufficient to solicit grant applications this year.

4. **AMA Curriculum Committee:** The Council on Scientific Activities would like to recognize its former Chairman and current FMA Vice President, J. Lee Dockery, M.D., for his outstanding leadership in organizing and directing the AMA Mid-Winter Scientific Meeting at Miami Beach in December 1977. The remarkable success of this continuing education meeting is also a tribute to the many FMA members who contributed their time so generously and effectively.

Council on Specialty Medicine

The motion of the Reference Committee that the report of the Council on Specialty Medicine be adopted as printed in the handbook carried.

Council on Specialty Medicine

Frederick C. Andrews, M.D., Chairman

The Council on Specialty Medicine held three meetings during the Association year 1977-78: on September 10, 1977, December 10, 1977, and February 18, 1978, all in Orlando. In addition, the Council's Subcommittee on Physician Population Ratios and Subcommittee on Criteria for Recognition of Specialty Groups held meetings in conjunction with these meeting dates.

Presently, the Council is composed of 37 FMA recognized specialty groups. The following is a summary of the Council's activities:

HSA Committee — The Council endorsed the action taken by the Board of Governors in establishing an HSA Committee with full-time staff to monitor HSA activities.

FMA Recognition Program — For two years the Council's Subcommittee on Criteria for Recognition of Specialty Groups has been trying to develop new and meaningful criteria for FMA recognition of specialty groups. This year, the Board of Governors approved the Council's recommendation for the establishment of an annual recognition program requiring submission of an application by September 1st of each year which must include certain documentation and a written response to the approved guidelines for recognition.

During this reporting period, the Florida Society of Clinical Oncologists received formal FMA recognition.

Electroconvulsive Shock Treatment — A report was received that the Church of Scientology would seek State legislation prohibiting

electroconvulsive shock treatment. The Council does not feel it is in the best interest of the patient to legislate matters of medical judgment and made a recommendation that FMA oppose legislation whereby individual choice of treatment would be made statutory.

Raw Unpasteurized Milk — There is increasing frequency in physicians writing prescriptions for raw unpasteurized milk. Present Florida law prohibits the sale of unpasteurized milk. Nevertheless, a system has been developed for allowing commercial dairies to honor a physician's prescription. The procedure is time consuming and inconvenient for all concerned. The Council took the position that there is no substantive evidence that raw milk as compared to pasteurized milk has any therapeutic value.

Family Practice Residency Programs — Information was received that the residents of some family practice programs have complained that they are not receiving sufficient training because other specialties were reluctant to participate in the training program. The Council endorsed the concept of family practice residency programs and urged all specialty groups to participate.

Medicare B — Office Visit Codes — The Bureau of Health Insurance originally agreed to recognize the five-digit code for reporting procedures and for a year the carrier profiled codes individually but has now received instructions from the Bureau which requires the lumping together of various types of office visits under a single code. Therefore, office visits which require a higher level of care will not receive proper reimbursement. The Council recommended that the FMA contact the Bureau of Health Insurance and request that all recognized codes be profiled individually for reimbursement purposes.

Physician Population Ratios — The Council's Subcommittee on Physician Population Ratios met on two occasions this year and reviewed the results of their survey of specialty groups requesting information as to the optimal number of physicians by specialty per 100,000 population. The replies received were not sufficient to make a conclusive report and the Subcommittee has decided to make another survey with more specific questions.

Laetrile — The laetrile law passed during the 1977 Legislative session contains a provision which states that should the Board of Medical Examiners find that the use of laetrile is harmful, they may recommend that its use be prohibited. The Council endorsed the stand of the Florida Cancer Council against laetrile and other unproven methods of medical treatment until such time as proponents of such treatment present scientific sound data which is approved by the Food and Drug Administration (F.D.A.).

Moxibustion — Recently the Council reviewed an inquiry from a county medical society requesting an FMA position with regard to the practice of performing acupuncture and moxibustion techniques.

Moxibustion is the application of heat to acupuncture points by burning moxa (dried leaves). The end result of this type of treatment could be second and third degree burns. The Council took the position that the practice of moxibustion is a cult.

Home Delivery — The popularity of home delivery in obstetrical care is increasing and the Council has endorsed the Florida Obstetric and Gynecological Society's position of opposing home delivery because it is not possible even with excellent pre-natal screening to identify all of the patients who will suddenly develop serious complications in labor.

Legislation — The Council received numerous referrals from the Committee on State Legislation regarding pre-filed Senate and House bills, which covered a wide range of subjects. Each bill was considered with recommendations being forwarded to both the Committee on State Legislation and Board of Governors.

BOARD OF GOVERNORS REPORT
Referrals by the 1977 House of Delegates

Pap Smears

Recommendation No. 1

The motion of the Reference Committee that the Board's report on Pap Smears and Recommendation No. 1 be adopted carried. (See Board Report, page 530.)

Board Actions of Major Importance

American Cancer Society Resolution on Smoking

Recommendation No. 4

The motion of the Reference Committee that the Board action on the American Cancer Society Resolution on Smoking and Recommendation No. 4 be adopted carried. (See Board Report, page 533.)

FMA Councils and Committees

Council on Scientific Activities

The motion of the Reference Committee that the Board's report on the Council on Scientific Activities, including Recommendations 7 and 8 be adopted carried. (See Board Report, page 537.)

Council on Specialty Medicine

The motion of the Reference Committee that the Board's report on the Council on Specialty Medicine, including Recommendations 9, 10, 11, 12, 13, and 14, be adopted carried. (See Board Report, page 538.)

Board of Governors — Supplemental Report

Continuing Medical Education Records

The motion of the Reference Committee that the Supplemental Report of the Board on Continuing Medical Education Records be adopted carried. (See Supplemental Report of Board, page 546.)

Resolution 78-12

Substandard-Trained Physicians

Pinellas County Medical Society

The motion of the Reference Committee to amend Resolution 78-12, Substandard-Trained Physicians, carried.

The motion of the Reference Committee that Resolution 78-12 be adopted as amended carried.

RESOLUTION 78-12

Substandard Trained Physicians

RESOLVED, That the Florida Medical Association requests the American Medical Association Committee on Medical Education develop a feedback mechanism for identification of those physicians who have been found by their local county medical societies or hospital staffs to be inadequately trained in their specialty.

Resolution 78-18

Cancer Epidemiological Center and Registry

Dade County Medical Association

The motion of the Reference Committee that Resolution 78-18 be amended carried.

The motion of the Reference Committee that Resolution 78-18 be adopted as amended carried.

RESOLUTION 78-18

Cancer Epidemiological Center and Registry

RESOLVED, That the Florida Medical Association support the concept of a cancer epidemiological center with a state-wide cancer registry for the purposes of collecting and disseminating analyzed data to hospitals and authorized persons in order to enhance the control of cancer (with adequate protection of the confidentiality of such information).

The Committee commended Dr. Yank D. Coble, Jr., Chairman of the Council on Scientific Activities and the members of his Council, and Dr. Frederick C. Andrews, Chairman of the Council on Specialty Medicine and the members of his Council, for their efforts on behalf of the Association throughout the year.

The Chairman thanked the members of this Committee, Drs. Vincent P. Corso, David S. Hubbell, and Karl L. Rolls, for their dedicated participation in the hearings of this Reference Committee and the preparation of this report. The Committee also thanked AMA Delegates Drs. Richard G. Connar and James T. Cook, for their very helpful advice to the Committee. The Committee thanked Mrs. Cindy Kelly, recording secretary, for her efficiency in preparing the report, and Mr. Edward D. Hagan, FMA Staff, for his counsel to the Committee.

The motion of the Reference Committee that the report of Reference Committee No. I be adopted as a whole as amended carried.

A request was made from the floor by James R. Jude, M.D., Dade, to introduce an emergency resolution. The Speaker advised the unanimous consent of the House was required. Unanimous consent was granted, and the Resolution was presented.

An amendment was moved, the motion carried and Resolution 78-26, as amended, was adopted by the House.

RESOLUTION 78-26

President of the United States

Whereas, The President of the United States has recently stated that organized medicine is more interested in the financial protection of its members rather than advancement of medical science and patient care; and

Whereas, Medical physicians are profoundly hurt and discomforted in this attack on them and their patient's confidence; and

Whereas, The history of American medicine indicates that it is the most advanced and progressive in the world and has consistently over the years demonstrated by its actions concern for the patient rather than itself, therefore be it

RESOLVED, That the House of Delegates of the Florida Medical Association go on record as repudiating the unjustified attack of the President of the United States on the American Medical Association and the physicians, patient care and advancement of medical science which it represents.

Elections

President-Elect

The President opened the floor for nominations for the office of President-Elect of the Association for 1978-79.

Dr. Francis Coleman of Hillsborough County placed in nomination the name of Dr. Richard S. Hodes of Tampa.

Dr. Hodes' nomination was seconded by Dr. Charles Tate of Dade; Dr. David C. Lane, of Broward; Dr. David S. Hubbell, Pinellas; Dr. John Kruse, Duval; Dr. Robert N. Webster, Capital; and Dr. Samuel E. Kaplan, Sarasota.

Dr. Philip B. Phillips of Escambia County placed in nomination the name of Dr. Charles J. Kahn of Pensacola.

Dr. Kahn's nomination was seconded by Dr. Calvim W. Martin, DeSoto-Hardee-Glades; Dr. James F. Richards Jr., Orange; Dr. James T. Cook, FMA Past President; Dr. Franklin H. Pfeiffenberger, Sarasota; and Dr. Emmet F. Ferguson Jr., of Duval.

Nominations were closed and upon secret written ballot Dr. Hodes was elected.

Dr. Kahn moved that a unanimous vote be recorded for Dr. Hodes. The motion carried.

Vice President

The floor was opened for nominations for the office of Vice President.

Dr. Thomas Caswell of Polk County placed in nomination the name of Dr. John W. Glotfelty of Lakeland.

Dr. Glotfelty's nomination was seconded by Dr. Roger A. Meyer of Manatee; Dr. Arthur L. Eberly, Broward; Dr. Richard Q. Penick, Martin; and Dr. Theodore W. Hahn, Broward.

Dr. David R. Arrowsmith of Okaloosa County placed in nomination the name of Dr. William W. Thompson of Ft. Walton Beach.

Dr. Thompson's nomination was seconded by Dr. James G. White of Volusia; Dr. George P. Messenger, Broward; Dr. Luis M. Perez, Seminole; Dr. Donald G. Nikolaus, Pinellas; and Dr. Vincent P. Corso, Dade.

Nominations were closed and upon secret written ballot Dr. Thompson was elected.

Dr. Glotfelty moved that a unanimous vote be recorded for Dr. Thompson. The motion carried.

Speaker of the House
Vice Speaker
Secretary
Treasurer
AMA Delegates and Alternates

The floor was opened for nominations for the office of Speaker of the House.

Dr. Everett Shockett of Dade County moved that all of the names of the announced unopposed candidates for Speaker of the House, Vice Speaker, and Treasurer and the incumbents for Secretary and AMA Delegates and Alternates, Seats No. 3, No. 2 and No. 5, be placed in nomination and that nominations be closed. The motion carried. All nominees to the stated offices were elected by unanimous vote of the House and are:

Speaker of the House — Sanford A. Mullen, M.D.
Vice Speaker — James B. Perry, M.D.
Secretary — Robert E. Windom, M.D.
Treasurer — J. Russell Forlaw, M.D.
AMA Delegates and Alternates
Terms 1-1-79 — 12-31-80
Seat # 3 — Delegate — Charles K. Donegan, M.D.
Alternate — Francis C. Coleman, M.D.
Seat # 2 — Delegate — Samuel M. Day, M.D.
Alternate — Jack Q. Cleveland, M.D.
Seat # 5 — Delegate — Richard G. Connar, M.D.
Alternate — Vernon B. Astler, M.D.

Judicial Council

The President referred the House to the report of the Board of Governors, in which the Board had nominated Dr. Robert J. Brennan, Ft. Lauderdale, for election to the Judicial Council from District C for a five year term expiring in 1983.

The nomination was adopted and Dr. Brennan was elected.



Richard S. Hodes, M.D., of Tampa, is escorted to the podium (left picture) after it was announced that delegates had chosen him as the new President-Elect. Escorting Dr. Hodes are Thomas E. McKell, M.D., (left) and Francis C. Coleman, M.D., both also of Tampa. At right, Dr. Hodes addresses the House for the first time as President-Elect.

Committee on Membership and Discipline

The President referred the House to the nominations for election to the Committee on Membership and Discipline as submitted by the Board of Governors in its report and asked for additional nominations from the floor. There were no additional nominations from the floor. Motion carried to elect the nominees submitted by the Board of Governors to the Committee on Membership and Discipline. (See Board Report, page 536.)

President Davenport introduced his wife, Carolyn; Dr. Caroline Hunter, and his office nurses. He also introduced his partners Dr. Glenn Salkind and Dr. Paul Gluck.

The President then introduced the new Board of Governor and announced that the Board would meet immediately following adjournment of the House.

The Speaker resumed the Chair and called on Dr. Jack Cleveland, Past President, for the Benediction.

Dr. Cleveland: "God give us men. The time demands strong minds, great hearts, true faith and willing hands. Men who the lust of office will not kill; men whom the spoils of office cannot buy; men who possess opinions and a will; men who have honor; men who will not lie; men who can stand before a demagogue an damn his treacherous flatteries without winking; tall men, sun crowned, who live above the fog, in public duty and in private thinking. And may the Lord keep us safely, and bless our efforts. Amen."

The 1978 House of Delegates adjourned at 12:00 noon.



Only moments after the gavel sounded the end of the 104th Annual Meeting, the new Board of Governors met for the first time and sat for this picture. Front row: Dr. J. Russell Forlaw, Boynton Beach, Treasurer; Dr. Robert E. Windom, Sarasota, Secretary; Dr. Richard S. Hodes, Tampa, President-Elect; Dr. Louis C. Murray, Orlando, Immediate Past President; Dr. O. William Davenport, Miami, President; Dr. William W. Thompson, Fort Walton Beach, Vice President; Dr. Sanford A. Mullen, Jacksonville, Speaker of the House; Dr. Jack A. MaCris, St. Petersburg, Past President; and Dr. Thomas B. Thames, Orlando, Medical District "C." Standing: Dr. James B. Perry, Fort Lauderdale, Vice Speaker; Dr. Charles J. Kahn, Pensacola, At Large; Dr. Norman Kenyon, South Miami, Medical District "D"; Dr. Joseph G. Matthews, Orlando, Blue Shield; Dr. J. Lee Dockery, Gainesville, Medical District "A"; Dr. Donald G. Nikolaus, Dunedin, Medical District "B"; Dr. Benjamin M. Cole, Orlando, State Board of Medical Examiners; Dr. Rufus K. Broadaway, Miami, AMA Delegate; Dr. Eugene G. Peek Jr., Ocala, Department of Health and Rehabilitative Services; Dr. Vernon B. Astler, Boynton Beach, Florida Physicians' Insurance Reciprocal; and Dr. W. Harold Parham, Jacksonville, Executive Vice President.

Our new Medical Necessity Program has two worthy goals:

(1) To help contain costs.
(2) To upgrade medical care.

This program initially identifies 28 surgical and diagnostic procedures which will not be paid routinely by Blue Shield. All pertinent claims will be reviewed for medical necessity and covered only when a clear need can be proven.

Following is a list identifying the 28 surgical and diagnostic procedures:

1. Ligation of Internal Mammary Arteries, Unilateral or Bilateral
2. Radical Hemorrhoidectomy, Whitehead Type
3. Omentopexy — Portal Obstruction
4. Kidney Decapsulation, Unilateral and Bilateral
5. Perirenal Insufflation
6. Nephropexy
7. Circumcision, Female
8. Hysterotomy
9. Supracervical Hysterectomy
10. Uterine Suspension
11. Uterine Suspension with Presacral Sympathectomy
12. Hypogastric or Presacral Neurectomy
13. Fascia Lata by Stripper — when used to treat lower back pain
14. Fascia Lata by Incision — when used to treat lower back pain
15. Ligation of Femoral Vein, Unilateral and Bilateral — when used to treat Post Phlebitic Syndrome
16. Excision of Carotid Body Tumor — when used to treat Asthma
17. Sympathectomy, Thoracolumbar, Unilateral or Bilateral — when used to treat Hypertension
18. Sympathectomy, Lumbar — when used to treat Hypertension
19. Basal Metabolic Rate — BMR
20. Protein Bound Iodine — PBI
21. Icterus Index
22. Ballistocardiogram — BCG
23. Phonocardiogram with Interpretation and Report
24. Angiocardiography, using Carbon Dioxide, Supervision and Interpretation Only
25. Angiocardiography, Single Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
26. Angiocardiography, Multi-Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
27. Angiography — Coronary, Unilateral, Selective Injection, Supervision and Interpretation Only, Single View unless in an Emergency
28. Angiography Extremity

This program was developed in cooperation with The American College of Physicians, The American College of Surgeons and The American College of Radiology. We ask your support in making our Medical Necessity Program 100% effective.*

*A claims review by The Florida Plan indicated that most of the procedures were already being screened for medical need and few of the services in question were being performed in Florida.



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JULY 1978 • VOL 65 • NO 7

Analysis of Acute and Chronic Thresholds and Reliability of Permanent Transvenous Pacing

R. Vijayanagar, M.D.; Diego A. Bognolo, M.D., and Paul F. Eckstein, M.D.

Abstract: We analyzed 138 consecutive pacemaker implants performed during the last three years. There have been 124 transvenous and 14 epicardial with no operative or in-hospital mortality. All patients were symptomatic except one. The most common indication for permanent pacing was sick sinus syndrome (32%) followed by complete heart block (28%). Acute thresholds obtained on 66 endocardial leads (mean 0.62 volts) were lower than 16 epicardial leads (mean 0.99 volts). Chronic threshold analysis of 20 transvenous electrodes seven to 37 months after insertion were (mean 2.05 volts) acceptable for long-term pacing. In no patient was an epicardial pacer necessary because of failure of transvenous pacing. The most disturbing complication, electrode dislocation (26.6% for bipolar leads), has been significantly lowered (3.8%) by using small tipped, lighter, monopolar endocardial electrodes.

Permanent transvenous pacing is widely accepted as one of the methods of cardiac pacing.[1-5] The object of this communication is to show the superiority, relative safety, and reliability of this procedure in this series of patients. The most disturbing complication, electrode dislocation, has been analyzed and a possible solution offered.

Clinical Material

In a three year period from January 1974 to February 1977 there have been 138 consecutive pacemaker implants. Of these 124 were transvenous implants and 14 epicardial implants which were performed concomitant with open heart surgery and one with thoracotomy for a lobectomy. The youngest patient was 49 and the oldest 97 years of age, 72 were male and 66 female. All were symptomatic except for one with complete heart block. Symptoms included dizzy spells, syncope, palpitations, lightheadedness, congestive heart failure, and anginal syndrome. The most common indication for pacing (Table 1) was sick sinus syndrome (31.8%). This was followed by complete heart block (28.2%); atrial fibrillation, flutter with slow ventricular response and syncope or symptoms of congestive heart failure (23.1%); fascicular block with symptoms (11.9%) and miscellaneous causes (5%). Seventy-six implants were performed under general anesthesia because of patient choice and good general condition and 62 with local anesthesia (1-2% Xylocaine). There were no complications due to anesthesia. A standard infraclavicular incision was used for transvenous implants. Cephalic veins or external jugular veins were used; on rare occasions the internal jugular vein was used for the passage of the electrode. There were 79 unipolar and 45 bipolar endocardial leads. Mercury-zinc or lithium powered pulse generators were used for the entire series.

Table 1. — Indications for Permanent Pacing

Diagnosis	Number	Percent
Sick Sinus Syndrome	44	31.8
Complete Heart Block	39	28.2
Atrial Fibrillation, Flutter with Slow Ventricular Response and Syncope or Congestive Heart Failure	32	23.1
Fascicular Block with Symptoms	16	11.9
Miscellaneous (hypersensitive carotid syndrome, symptomatic sinus bradycardia, etc.)	4	5.0
TOTAL	138	100

The latest Medtronic analyzer (Model PSA 5300) makes it possible to obtain satisfactory data including "R" wave thresholds. A V_1 lead ECG during the procedure was also taken to ascertain the position of the electrode in the right ventricular apex. To make the data uniform, threshold analysis in voltage form only is listed in Table 2. It is apparent from the data that the voltage criteria for endocardial leads is lower[6,7] although the relatively

From the Thoracic Surgical Section, Tampa General Hospital, Tampa.

higher voltage for epicardial electrode could have been due to metabolic insult of cardiopulmonary bypass as well as cardiac hypothermia. Chronic thresholds for 20 endocardial leads, in place for seven to 37 months, were mean 2.05 volts, satisfactory for long-term pacing[8] (Table 3). These chronic measurements were carried out during elective pulse generator replacements, premature battery failure and pacer recall by the manufacturer.

Table 2. — Acute Cathodal Threshold Analysis at 0.5 Msec-Pulse Duration.

Type of Lead	Number	Low	High	Mean
Endocardial Ball Tip (1.5 and 2 mm.)	66	0.2 volts	1.2 volts	0.62
Epicardial Screw-In Medtronic Leads. Left Vent. Myocardium	16	0.3 volts	2.1 volts*	0.99

*This was the threshold in one of the two epicardial electrode and one with 2.1 volts was not used.

Table 3. — Chronic Cathodal Threshold Analysis of Endocardial Leads at 0.5 Msec-Pulse Duration.

Duration	Thresholds
7-37 months after date of implant	Low — 0.8 volts High — 3.4 volts Mean — 2.05 volts

Table 4. — Complications, Early and Late.

Type of Complication	Number	Outcome
Pacing of Diaghragm	1	Stopped Spontaneously
Exit Block	10 Unipolar 6 Bipolar 4 Percent 8	Repositioned
Electrode Dislocation	Unipolar 3/79 or 3.7% Bipolar 12/45 or 2.6%	Repositioned
Myocardial Perforation	0	
Twidler Syndrome	1	Untwisted and lead fixed
Battery Erosion	2	Rerouted
Runaway Pacemaker	1	Expired

Complications and Follow-Up

Complications are listed in Table 4. There has been no operative or in-hospital mortality. The most disturbing complication, electrode dislocation, 26.6% for bipolar leads, has been significantly lowered to 3.8% by using a small tipped, lighter, monopolar endocardial electrode.[5,9,10] In the last one and a half years we have nearly eliminated the use of bipolar electrodes, significantly reducing the number of repositioning procedures. In no patient was an epicardial pacer necessary because of failure of transvenous pacing although one patient required repositioning on three occasions. A total of 14 patients (10%) have been lost to follow-up and 14 patients have expired (Table 5). A total of 110 patients (80%) are alive and well and are monitored. It is interesting to note that our 97-year-old patient will be celebrating a centennial soon.

Each patient is provided with a transmitter upon their first visit to our office and instructed in its use. Those patients with intermittent pacer capture are also provided with a magnet. Patients with mercury-zinc batteries are followed transtelephonically every two months. Those with lithium batteries are followed every three months. In the past 36 months a total of seven pacer malfunctions have been detected by transtelephonic follow-up.[11,12]

Comments

We have described our experiences to confirm that transvenous permanent pacing of the heart is simple, safe, rapid and reliable for long term pacing.[1,12] Although rapid advances have been made in the field of pulse generators, electrode problems still persist.[5,10,13,14] The most common are dislocation and exit block.[1,2,5,13,15] The complication of dislocation occurring in bipolar electrodes was reduced to 3.8% by using a smaller tipped and a lighter monopolar endocardial electrode combined with our improved technique and experience in pacemaker surgery. Our experiences differ with those reported by Conklin and associates.[5] Their experience, based on 400 consecutive transvenous implants, was that dislocation of the unipolar electrode is slightly higher than for bipolar electrodes. However, the incidence of exit block, as defined by nondisplacement of electrode by x-ray and fluoroscopy and very high and unacceptable stimulation threshold, is slightly higher for

Table 5. — Late Causes of Death in 14 Patients.

Pacer Related	1
Cancer	1
Pulmonary Emboli	1
Peritonitis	1
Stroke	2
Congestive Heart Failure	4
Unknown	4
Total	14

monopolar leads.[5] Most of the electrode dislocations occur in the immediate postoperative period while exit block seems to be associated with chronicity of the electrode.[10,14,15] The reliability of pervenous leads over a period of years has been recently emphasized by Luceri et al;[16] the authors reported chronic threshold stability in 81% of the patients paced transvenously during an 11 year period of observation.

We have observed on a number of occasions in patients undergoing open heart surgery with previous transvenous pacer implants that the tip of the electrode is firmly adherent to the right ventricular apex. Although these hearts were manipulated, retracted and even inverted, the electrode failed to dislodge. An epicardial lead was placed for added safety but the transvenous pacer has worked satisfactorily in all cases.

In no patient was epicardial pacing necessary because of failure of transvenous pacing in our series, although the failure rate of transvenous pacing is listed between 1% and 16%.[3,4,5] Only one patient has died of a pacemaker problem (runaway pacer), (Table 5). Ninety percent of the patients are followed through transtelephonic communication which has been proven to be simple and gratifying.

Acknowledgement

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Medical Artifacts Collection at the University of Florida

As part of the growing program in medical humanities at the University of Florida College of Medicine, the Division of Social Sciences and Humanities is now offering courses, noon-time discussions, formal lectures, and spot teaching sessions on topics in the history and philosophy of medicine. Todd L. Savitt, Ph.D., a medical historian at the Health Center, is currently building a medical artifacts collection to demonstrate the ways in which medical thought and technology have changed over the years. At present the collection is quite small: a spring lancet, a glass cupping set, a set of craniotomy instruments, and a few assorted surgical tools. Shown in conjunction with slides illustrating their use, these instruments provide students with a real sense of the medical past not otherwise attainable. Savitt is anxious to expand this teaching collection both in breadth and depth. If you own or know the location of old medical instruments, and are willing to lend or donate them for educational purposes to the University of Florida College of Medicine, please contact Dr. Savitt at the following address.

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Heart Block and Cardiac Pacing

John J. LaRosa, M.D.

Abstract: Two hundred twenty-eight pacemaker procedures were performed at the Brevard Hospital during the period January 1, 1972 — December 31, 1976. This included 124 permanent implantations, 61 temporary pacemakers and 43 pulse generator replacements. Indications for permanent pacemaking include heart block and the sick sinus syndrome. Results and complications are discussed.

It is now well accepted that cardiac pacing is the treatment of choice for chronic atrioventricular conduction block. There have been over 250,000 pacemaker implantations in the world since Chardack performed the first operation in 1960. More than 50% have been in the United States and Canada.

Clinical Material and Methods

From January 1, 1972 to December 31, 1976, 228 pacemaker procedures were performed at the Brevard Hospital. Of this total, 124 were permanent implantations, 61 were temporary insertions and 43 were pulse generator replacements. Frequency distribution by age and sex is shown in Table 1. There were 87 women and 141 men in the series. Ninety percent were over 60 years old, 70% were over 70 years old and 23% were over 80 years old. Heart block associated with acute myocardial infarction was the leading indication for temporary pacing (Table 2). Indications for permanent pacemaker implantation are listed in Table 3. There were 57 (46%) patients with Stokes-Adams attacks. Symptomatic heart block was the indication in 33 (27%) patients. The sick sinus syndrome was the indication in 33 (27%) patients including the tachybrady syndrome. One patient had congenital heart block. Table 4 presents the types of pacemaking systems employed. In the permanent implantation group, the pervenous electrode was used in 111 (90%) patients, while the myocardial electrode was used in 13 (10%) patients. Table 5 demonstrates the types of pulse generators employed in our experience. The R-wave inhibited demand pacemaker was used in most cases (93%). Table 6 lists the thresholds achieved in permanent implantations measured by an external pulse generator. In over 90% of the permanent implants the threshold achieved was 0.9 m.A. or less. More recently, we have used a pacing

Table 1. — Frequency Distribution by Age and Sex.

Mean Age — 72

Age	Number Patients
Under 41	2
41-50	10
51-60	9
61-70	49
71-80	109
81-90	47
Over 90	2
Total	228
Sex	
Female	87
Male	141
Total	228

Table 2. — Indications for Temporary Pacing.

Indications	Number Patients
Acute myocardial infarction with AV block	42
Tachybrady arrhythmia	7
Sinus bradycardia	10
Pre-anesthesia	2
Total	61

Table 3. — Indications for Permanent Pacing.

Indications	Number Patients	(Percent)
Stokes-Adams attack	57	(45.4)
Complete heart block (symptomatic)	22	(18.3)
2° Heart block (symptomatic)	11	(9.1)
Sick sinus syndrome	14	(11.1)
Tachybrady syndrome	19	(15.3)
Congenital heart block	1	(0.8)
Total	124	(100)

Table 4. — Types of System.

Type	Number
Temporary	61
Permanent	
Pervenous	111
Myocardial	13
Total	185

Table 5. — Types of Pulse Generators.

Type	Number
Fixed rate	6
Demand	
R-wave inhibited	116
R-wave synchronous	2
Total	124

Table 6. — Pacing Thresholds.

m.A.	Number	(Percent)
Less than 0.5	43	(34.6)
0.5 - 0.9	69	(55.7)
1.0 - 1.5	9	(7.3)
Greater than 1.5	3	(2.4)
Total	124	(100)

system analyzer for more detailed studies of threshold, R-wave sensing and lead resistance.

Temporary pacing is achieved by the percutaneous catheterization of the subclavian vein in the Coronary Care Unit without fluoroscopy. Permanent pacing is accomplished by pervenous (endocardial) and myocardial systems. The pervenous implantation is carried out in the catheterization lab under sterile conditions with local anesthesia, using fluoroscopy and image intensification.

Myocardial implantation has been reserved for those patients in which satisfactory endocardial pacing cannot be maintained due to technical problems during the pervenous implantation, wire migration, infection and extrusion of the system. In addition, younger patients with congenital heart block are also candidates for myocardial implantation.

We have now adopted the screw-in (sutureless) technique through a subxiphoid approach to the heart. The procedure is performed in the operating room under general endotracheal anesthesia.

Results

There were 37 (29.3%) complications in this series of 124 permanent implantations (Table 7). The most common was lead migration. Thirteen (10.4%) patients required repositioning of their lead electrode, one of these was a sutureless lead implant performed early in our experience with this method. In two cases of lead migration diaphragmatic pacing was noted. Most cases of lead displacement occurred during the early postoperative period (less than seven days). However, two patients had late lead displacement several months postimplant.

There were 16 (12.7%) wound complications. This included 11 (8.8%) sterile hematoma. Six of these patients had been on anticoagulants immediately prior to implantation. They were all managed successfully with drainage by aspiration or incision without loss of the implantation system. This particular complication should reemphasize the need to return the patient's coagulation mechanism to normal prior to pacemaker implant.

Two (1.5%) patients had erosion of their pulse generator, and one patient's lead eroded through the skin of the neck incision. Correction by myocardial implantation was chosen in two of these complications and wire splicing in the third case. Skin erosion continues to be a problem with implantation because of the thin subcutaneous layer in these elderly patients.[1] We have elected to implant the pulse generator under the pectoralis muscle in thin patients. In addition, we have avoided the external jugular vein as the site of the pervenous implantation whenever possible, thus avoiding erosion in the neck. If the jugular vein must be utilized, retroclavicular tunneling is employed in thin subjects.

There were two (1.5%) wound infections. In both cases conservative management by drainage and irrigation with povidone or antibiotics resulted in healing of the wound.[2] We feel pre- and postoperative antibiotics, intraoperative irrigation with povidone or antibiotics and strict adherence to surgical technique during the operative procedure will continue to assure low infection rates.

Two (1.5%) instances of lead fracture more than one year postimplantation required system replacement; one of these was a sutureless lead which had wound around itself causing multiple fractures.

There were no documented instances of cardiac perforation although the two cases of diaphragmatic pacing mentioned earlier may well have represented this complication.

There were four cases of premature battery failure (less than one year) necessitating battery replacement.

Table 7. — Complications.

Type	Number	(Percent)
Infection	2	(1.5)
Erosion	3	(2.4)
Sterile "seroma"	11	(8.8)
Lead displacement	13	(10.4)
Lead fracture	2	(1.5)
Perforation	0	(0)
Faulty sensing	2	(1.5)
Battery failure	4	(3.2)
Total	37	(29.3)

There were two cases of faulty sensing, one of which may have contributed to a death. In the other case of a suture myocardial lead, the patient refused further corrective measures.

Long term patient follow-up is continued by the internists in the community.

Deaths

There were four (3.2%) deaths within 30 days in this series; however, only two (1.6%) could be related to the pacemaker procedure. There were no deaths in the myocardial implantation group.

An 80-year-old male, 21 days postimplantation, was admitted to the emergency room with an acute myocardial infarction and expired soon after admission. An electrocardiogram revealed normal pacing function.

A 61-year-old male, 20 days postimplantation, was admitted with lead migration. The lead electrode was relocated with satisfactory threshold and pacing function. Four days later the patient expired. Postmortem revealed massive thrombosis of the superior vena cava, right atrium and pulmonary artery. Venous thrombosis along the lead electrode is uncommon. Pulmonary emboli from this complication must be rare indeed.[3]

A 65-year-old male, 19 days postimplantation, was admitted with sensing failure. He had suffered three previous myocardial infarctions with congestive heart failure. The patient had had a recent anteroseptal infarction and it is postulated that exit block at the site of the infarction resulted in sensing failure. The patient expired within hours of readmission. It has been reported that patients with chronic congestive heart failure have a higher mortality rate following pacemaker implantation.[4]

An 84-year-old male, three days postimplantation, expired. He was found to have metastatic liver disease unknown at the time of implantation.

Generator Replacement

There are 43 battery replacements in this series (Table 8). Twenty-one replacements were elective with the generator age having reached the manufacturer's predicted longevity, while 17 replacements were required for battery failure manifest by slowing rate. In four instances, pulse generator replacement was performed because of extrusion of a generator which had been implanted at another institution.

Table 8. — Battery Replacement.

Indication	Number
Elective	21
Slowing	17
Extrusion	4
Loss of sensing	1
Total	43

Comment

Temporary pacing is applicable in a number of clinical situations such as acute myocardial infarction and surgical patients with bradycardia.

In the first decade of permanent cardiac pacing, complete heart block was the indication for pacemaker implantation in 80% of the patients. In more recent years, wider application for permanent pacemaking has evolved. Intermittent heart block and sinoatrial disease now account for about 60-65% of the indications for permanent pacing while less than 35% of the indications are for complete heart block.[5] In our series these figures are comparable. The sick sinus syndrome as described by Lown and Ferrer[5] has become a prominent indication for permanent pacing. This syndrome includes sinus bradycardia, sinus arrest, with or without escape rhythms, chronic atrial fibrillation with slow ventricular response not caused by drug therapy and tachybrady arrhythmias.

Approximately 20-33% of patients with heart block requiring pacemakers revert to intermittent block.[6,7] If A-V conduction should return and competition occurs, dangerous ventricular arrhythmias may develop due to stimulation within the vulnerable period. For these reasons, we are now employing demand pacemakers in all patients for the initial implantation. However, complications continue to present a challenge to the clinician. In our series, a 29.3% complication rate compares favorably with other reported experiences (24-40%).[8,9] The total incidence of catheter complications was 12.1% compared with other reported series (11-18%)[9-11]

Cardiac pacemaking is well established as a therapeutic modality in the treatment of atrioventricular conduction disease.

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● Dr. LaRosa, 1405 South Pine Street, Melbourne 32901.

St. Louis Encephalitis

R. Michael Yeller, M.D.

A total of 110 cases of St. Louis encephalitis (SLE) were reported to Disease Control in Tallahassee during the four-month period August 8 through December 15, 1977. Seventy-seven of the cases were confirmed and 33 were presumptive (Fig. 1). This is the highest number recorded in a single year since the Tampa Bay epidemic

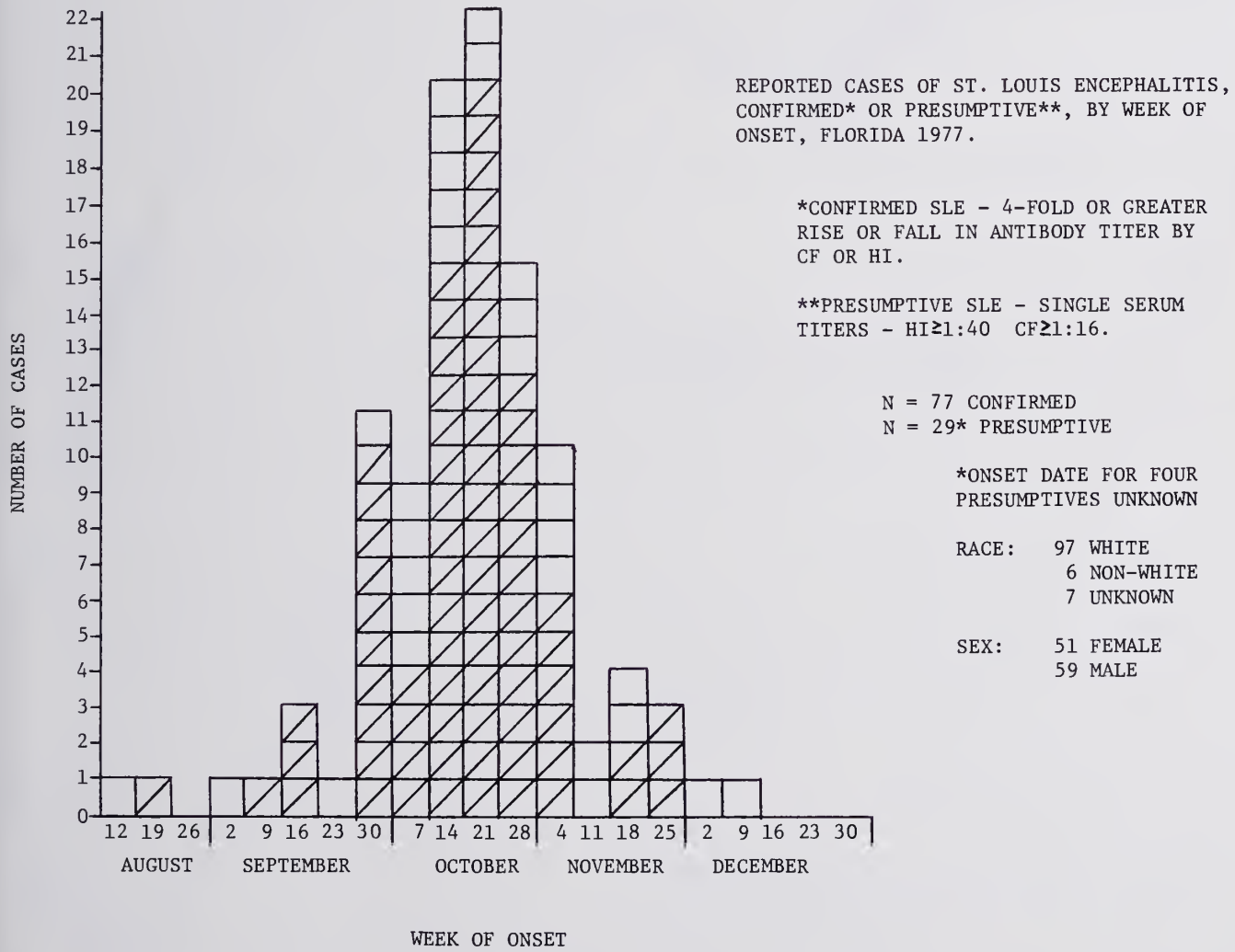


Fig. 1. — Cases of confirmed or presumptive St. Louis encephalitis by week of onset. Confirmed — 4-fold or greater rise or fall in antibody titer by CF or HI. Presumptive — single serum titers HI ≥ 1/40, CF ≥ 1/16.

Dr. Yeller is Administrator/State Epidemiologist, Disease Control, Department of Health and Rehabilitative Services, Tallahassee.

of 1962 and is greater than the total reported for the remainder of the United States during 1977. Known disease occurred in 19 counties (Fig. 2) and people of all ages had the infection but almost two thirds of identified cases were in the 55 year old and older group (Fig. 3).

The SLE virus was isolated from pools of Culex nigripalpus mosquitoes taken from central and southern Florida. This species appears to be the principal vector of the disease in Florida. Investigation is yet to be assessed regarding Culex quinquefasciatus and Culex salinarius. Serological results from sentinel chicken flocks indicated an extremely high level of virus activities.

Surveillance and control programming for the remaining months of 1978 would be greatly assisted if all physicians and hospitals retain a high index of suspicion for encephalitis (Table 1) and utilize the appropriate serological mechanisms for diagnosis (Table 1).

Mosquito control activities in the affected areas and surveillance for human cases are being continued.

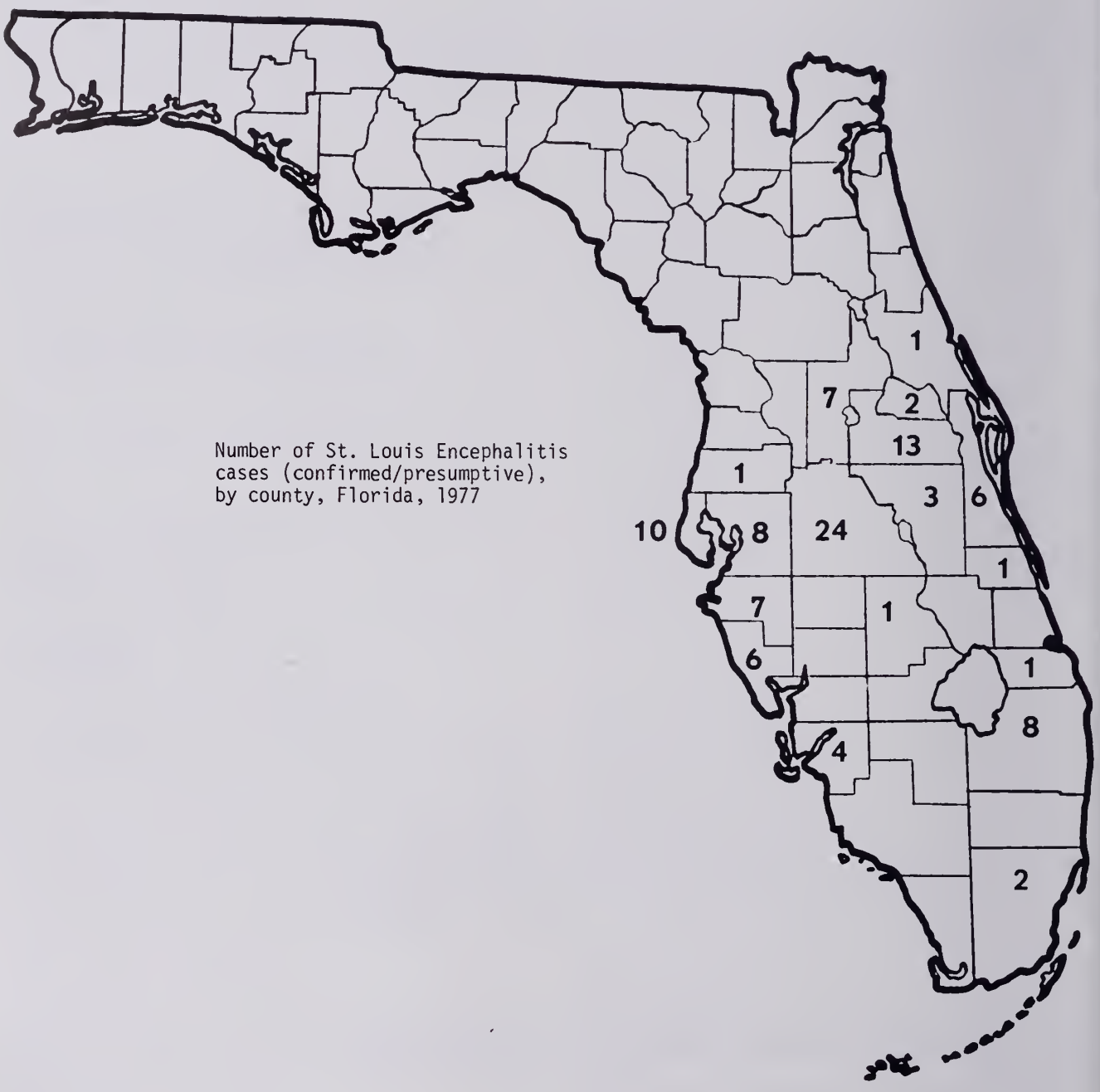


Fig. 2. — Number of St. Louis encephalitis cases by county.

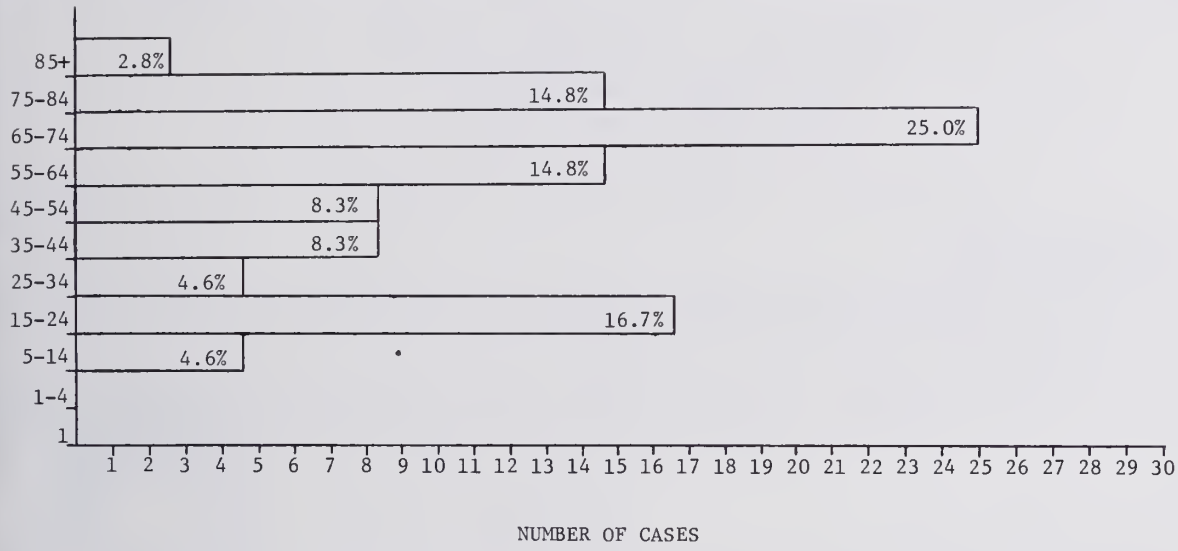


Fig. 3. — St. Louis encephalitis cases by age group.

Table 1. — Criteria for Classification of St. Louis Encephalitis Infections Among Humans.

Clinical Categories

Encephalitis including meningoencephalitis and encephalomyelitis (both signs under A and B)

A. Acute febrile illness (temperature $\geq$ 100F)

B. One or more signs under 1 or 2 or both

1. Profound alteration in state or level of consciousness (confusion, disorientation, delerium, lethargy, stupor, coma, etc.)

2. Objective signs of CNS dysfunction (tremor, dysarthria, hyperreflexia, rigidity, cranial nerve palsy, convulsion, paralysis, etc.)

Aseptic meningitis (all signs under A, B and C)

A. Acute febrile illness (temperature $\geq$ 100F)

B. Occurrence of either 1 or 2 or both

1. One or more signs of meningeal irritation (stiff neck, positive Kernig or Brudzinski signs)

2. Pleocytosis (5 or more WBC/cc)

C. Absence of encephalitis and meningitis of bacterial or other nonviral etiology.

Other illness

Febrile headache or other syndromes but not encephalitis or aseptic meningitis

No clinical disease

No symptoms

Laboratory Categories

Confirmed SLE

A. 4-fold or greater rise or fall in antibody titer by CF, HI or 1.3 logs of neutraliziation testing, or

B. Isolation of virus from patient

Presumptive SLE

Single serum titers — HI $\geq$ 1/80
CF $\geq$ 1/16

Inconclusive

A. Highest titer HI $<$ 1/80 or CF $<$ 1/16 and not satisfying criteria for confirmed or negative case, or

B. Unsatisfactory serologic data

Negative

No titer or stable low titers (e.g., HI in range of 10-20) in appropriately paired sera and no virus isolation.

● Dr. Yeller, 1323 Winewood Boulevard, Tallahassee 32301.

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF INTERNAL MEDICINE

Fifth Annual Review Course

"FUNDAMENTAL AND CLINICAL ASPECTS OF INTERNAL MEDICINE"

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ORGANIZATION

American College of Nuclear Physicians Elects Dr. Lawrence R. Muroff

Lawrence R. Muroff, M.D., of Tampa, has been named President-Elect of the American College of Nuclear Physicians. At 35, he is the youngest physician ever designated to head the College.



Dr. Muroff

Dr. Muroff, formerly a Regent of the College, was elevated to President-Elect of the 1,200-member organization at its Annual Convention last February in San Francisco. He will be installed as President at the next convention, scheduled for San Juan, P.R.

Edward A. Eikman, M.D., also of Tampa, was chosen to succeed Dr. Muroff as Regent.

A native of Philadelphia, Dr. Muroff is a graduate of Dartmouth College, where he earned his Phi Beta Kappa key. He received his M.D. degree Cum Laude from Harvard in 1967. He is a Diplomate of the American Board of Radiology (Diagnostic) and of the American Board of Nuclear Medicine.

His present professional appointments include Director of the Department of Nuclear Medicine at University Community Hospital in Tampa; and Clinical Assistant Professor of Radiology (Nuclear Medicine) at the University of South Florida College of Medicine.

At the state level, Dr. Muroff has served as President of the Florida Association of Nuclear Physicians; and is the representative for nuclear medicine on the FMA Council on Specialty Medicine. He also represents his specialty as a Consulting Editor of *The Journal.*

He has served in various capacities in the American College, including chairing the membership and program committees. He also has been active in the national Society of Nuclear Medicine, the Florida Radiological Society, and the Radiological Society of North America.

The new ACNP President-Elect is married to the former Carol Renee Savoy. They have two children, Michael, 4, and Julie, 1½.

Dr. Donald G. Nikolaus Is Finalist in M.D. of the Year Search

Donald G. Nikolaus, M.D., of Dunedin, a member of the Florida Medical Association Board of Governors, will be one of nine physicians featured in the October issue of *Good Housekeeping* magazine.



Dr. Nikolaus

The Pinellas County physician was one of the finalists in the magazine's search for its 1978 Family Doctor of the Year. Mario E. Ramirez, M.D., of Rio Grande, Texas, was singled out for the honor.

Dr. Nikolaus was nominated by the Florida Physicians, of which he is a Past President. He was one of 26 nominees nationally.

The contest was conducted with the cooperation of the American Academy of Family Physicians.

Dade County Medical Association Breaks Ground For New Headquarters Building

Groundbreaking ceremonies conducted on May 2 marked the beginning of construction of Dade County Medical Association's new headquarters building.

Several notables participated, including FMA President Louis C. Murray, M.D., of Orlando, and FMA Executive Vice President W. Harold Parham, D.H.A., of Jacksonville.

The building site is located at 1495 N.W. 13th Terrace near the medical center in downtown Miami. The building is estimated to cost $450,000 and is scheduled for completion early in 1979. It will have about 5,000 square feet of space on the ground floor and 6,000 square feet on the second floor for the administrative offices.

DCMA is the largest of FMA's component medical societies.



Participating in groundbreaking for the Dade County Medical Association's new home were (left to right): Marshall Hall, M.D., Chairman of the DCMA Board of Trustees; FMA Executive Vice President W. Harold Parham, D.H.A.; FMA President Louis C. Murray, M.D.; and Sol Center, M.D., DCMA President.

Medicaid Providers Are Advised of Program Change

The Department of Health and Rehabilitative Services has advised Medicaid providers that the 50-cent co-payment for drugs has been discontinued indefinitely.

Another important change is a limitation of three physician visits per month per Medicaid recipient. That change was effective on June 1, according to Mr. Walter B. Conwell, Program Administrator for Medical Services.

Other restrictions on dental service were also announced.

NORTH FLORIDA REGIONAL HOSPITAL
and
THE NORTH FLORIDA REGIONAL MEDICAL FOUNDATION
announce
THE FIFTH ANNUAL CARDIOVASCULAR SYMPOSIUM
September 14-15, 1978

The HILTON INN — Gainesville, Florida

Director: Howard W. Ramsey, M.D.
Co-Directors: Luis J. Cintado, M.D.
Thomas D. Bartley, M.D.

This fifth annual symposium is devoted primarily to a review and reappraisal of past and current concepts of diagnosis and treatment of coronary artery disease. A full and exhaustive review of recent data comparing medical and surgical therapy of patients with angina will be presented. Other topics to be discussed include bacterial endocarditis, the myocardiopathies and the current status of cardiac transplants.

A special section of the program, to be presented by Mr. Melvin Belli, will be devoted to an analysis and discussion of current medical-legal problems including the proliferation of malpractice suits.

An outstanding faculty has been assembled for the symposium and the program should be of interest to all physicians involved in the care of patients with cardiovascular problems.

FACULTY

Ralph Alley, M.D.
Christiaan Barnard, M.D.
Melvin Belli, Lawyer
Donald Effler, M.D.
Peter Gazes, M.D.
Goffredo Gensini, M.D.
J. Willis Hurst, M.D.
W. Dudley Johnson, M.D.
Arthur Mauceri, M.D.
Richard O. Russell Jr., M.D.
Earl K. Shirey, M.D.
Douglas R. Shanklin, M.D.
W. Jape Taylor, M.D.

As an organization accredited for continuing medical education, the Medical Education Committee of the Florida Medical Foundation certifies that this continuing medical education activity meets the criteria for 14 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. The medico-legal portion of the program is acceptable for 3 credit hours in Category 2. Approval for 18 hours Prescribed CE credit has been requested from the Florida Academy of Family Physicians, the Florida Board of Pharmacy and the American Society of Radiologic Technologists.

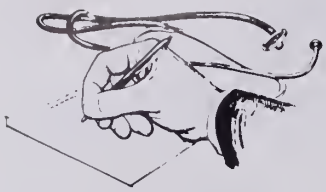
HOTEL RESERVATIONS: A block of rooms has been reserved at the Hilton Inn for symposium participants and reservations can be made through your local Hilton Inn, the Hilton Reservation Service (toll free number listed in your local telephone directory) or by calling the Gainesville Hilton Inn directly (904) 377-4000.

RESERVATION FEES: $175. - all physicians
50. - paramedical personnel (nurses, technicians, etc.)

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Program Director
North Florida Regional Hospital
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For further information, call: Dr. Howard Ramsey or Hazel Sessions (A.C. 904) 377-8511, extension 195.



Others Are Saying

Fragmentation of Medical Care

I see a new elite developing in the health care field. They are characterized by the casual draping of a stethescope about the neck and by speaking and writing in cryptic abbreviations. In fact these hallmarks have become as de rigeur as driving a pickup truck with a gun rack in the rear window. I'm speaking of the para-professional technologists who now people our institutions to maintain and operate our marvelous machines and assist with technical patient care. This is not to denigrate them as a class or individually for they are certainly vital to the provision of the best of patient care. The average physician can't understand the intricacies of all these machines and tests and doesn't really want to. They are far too diverse; however, I fear we may reach a condition of the tail wagging the dog. Each class of technologists is becoming more and more of a clique, organizing and demanding more and more autonomy. There is such a profusion of organizational abbreviations it boggles the mind. ANA, ALM, AORN, ART, CCUN, ICUT, APT, AOR, ARNA, AALT and on and on. Often the encompassed field is quite narrow. All this is well and good up to a point, in that it can ensure quality and pride in performance. A danger exists, however, in that it is easy for these groups to actually become mini unions acting in ways which could be detrimental to the provision of medical care: e.g., restriction of membership, feather bedding, and withholding a service. I fear this danger is real since with this degree of fragmentation no individual part of the whole carries the identifying marks of the profession with its resultant restraints.

Truly a technocracy is being established. Among the technologists I sense a disdain for those physicians who aren't in the club. This includes those with whom they don't work regularly, who don't understand their machines and who aren't privy to the code of their abbreviations. Those who merely try to take care of patients are beyond the pale.

Aside from the aforementioned dangers, I believe the main hazard at this time is economic. A medical pie has been created by third party payors and all parties concerned are clamoring for as big a piece of the pie as possible and naturally want their piece to get bigger and bigger. The only way to satisfy them is to make the pie bigger and bigger. Obviously a limit will be reached at some time. Then what? Again, I exhort the Doctor of Medicine to rise to the occasion. He is the only one who is able to have an overview of the entire field. It is he who must decide how and when to utilize the technologies available. He must look beyond personal aggrandizement. It is he who must be the unifying force which draws the fragments together into the unified whole.

In summary, we must all become true medical statesmen.

James K. Conn, M.D.
Tallahassee

Reprinted from The Capital Medical Society Newsletter #46, January 1978. Dr. Conn is Newsletter Editor.

Register To Vote!

What's in a Name?

One of the most effective journalistic ways to bring about change in social institutions is to change the language. George Orwell illustrated this technique in his book "1984." Along with other tools of manipulation, the word game has emerged as a key mechanism in this society as it rushes headlong into Orwell's "1984."

In the book, published in 1946, war becomes a synonym for peace. In Vietnam, peacemaking forces systematically eradicated whole villages. In bureaucratic Washington, women who are the majority of Americans are to have their rights dealt with by preserving the rights of minorities. In the Bakke case, the plaintiff argues that a California medical school's antidiscrimination policy is implemented by discrimination. The list goes on.

In the concerted twenty year attack on the American health care system, the word technique has reached heretofore unachieved dichotomies. Anyone who can get away with it and wants to treat the real or imagined sick manages to latch on to the label "doctor." On the other hand, the bureaucrats insist upon a label for the extensively educated physician as a "health care provider," a "provider" or a "vendor." (Anyone for popcorn or peanuts?)

The word technique over a period of time, if repeated continuously and often enough, can reduce the profession in the public mind to a point sufficient to destroy its influence. We, as doctors of medicine without appearing pompous, will have to insist upon appropriate labels for ourselves, our specialties, and our patients. To quote, "What's in a name? A rose by any other name would smell as sweet" may be a truism unless you forget that it is a rose you are smelling or that other things can be made to smell like roses — maybe even a thorn.

If people are to mean anything more true, identities must be preserved with proper and respectful labels. We should reject the concept of egalitarianism that erases identities or human dignity.

Humanity in medicine is controlled by a group of angels, and every time someone says "provider" instead of "physician" or "nurse," one of those angels dies; every time someone says "consumer" instead of "patient" or "person," another angel dies; and when all the angels are dead, the humanity in medicine will be gone.

Richard S. Hodes, M.D.
Tampa

Reprinted from The President's Page in the Bulletin of the Hillsborough County Medical Association, March 1978.

Yes Washington, There Is A Virginia

There has been a growing feeling in political circles in Washington that licensure in medicine should be a federal concern. Several arguments have been raised in favor of this concept. First, it is said that health care is a national matter which should not be artificially limited by state boundaries. Second, it is alleged that a federal licensing board would be free of control from "organized medicine" whereas the state medical boards are subservient to state medical societies and the AMA. Third, it is assumed that federal licensing would be free of bias with regard to sex, race, religion or color, while state medical boards discriminate along these lines.

Consumer groups, and their all-knowing physician spokesmen, have supported the federal government in these arguments. They add the proposition that state licensing is a mess, with poor examinations, irrelevant questions, biased grading techniques and limited endorsement from one state to another. Apparently, these groups have the naive belief that Big Brother could solve all the real or imaginary problems in the present state licensing system.

Is it important whether the physician is licensed and disciplined by Virginia or by Washington? Most individuals who are associated with state licensing boards believe that it is vital for states to retain this responsibility, one which is reserved to the individual state by the Tenth Amendment to the Constitution.

There are two other significant reasons for favoring state control. Each of them may well be more important and relevant in 1978 than the Tenth Amendment. First, the arguments against state licensing boards are patently false. Examinations are uniform. Examination questions

are scrutinized both by the National Board and the FLEX Test Committee to assure their significance. Grading is objective. Endorsement is broad since the use of National Boards and FLEX is almost universal.

Second, there is the problem of size. State medical boards in larger states are aware of the difficulties inherent in policing a large number of practitioners. Enlarging the base by giving this responsibility to one national agency would compound this problem many times over, and add enormously to the cost of medical care. If anything, the movement should be in the opposite direction. Hospital staffs and local medical organizations must exercise more authority in medical discipline. This can be better done under a state than a federal mandate. In large states, sub-boards with a more limited geographic responsibility would be better able to cope.

The federal establishment is not endowed with unique abilities. Unless evidence is presented to show that the federal government is able to handle the difficult problems of medical licensure better than the states, the federal authorities should leave medical licensing alone. This evidence simply does not exist in the United States today.

JHM

Reprinted from the Federation Bulletin, March 1978.

A Flight Of Fancy

This little gem was sent to Dr. Warren Bostic by Daniel P. McMahon, M.D., of New York. Unfortunately, we cannot determine where it originally appeared. All we know is that is was authored by a Robert B. Howard, M.D., "Consulting Editor." Nevertheless, we are unable to resist sharing it. Our thanks, Dr. Howard.

Flying an aircraft is much too serious a business to be left to the pilot. For far too long, pilots have enjoyed a kind of mystique which has permitted them to dominate the flight-care system in an unconscionable fashion. It is high time that we flight-care consumers asserted our fundamental rights.

I am tired of having the pilot tell me when I can board an aircraft, when I must buckle my seatbelt, at what altitude we will fly, and other comparable aspects of my flight-care consumption. The pilot, after all, is only one member of a flight-care team that also includes ticket sellers, boarding area personnel, cabin attendants, navigators, and co-pilots. The views of all these people, experts in their respective fields, should be taken into consideration when flight care is being planned and executed. Obviously, the interests of the consumers must also be respected.

I suggest that what we need in the United States is a massive restructuring of the flight-care system that will free us of this unhealthy dominance by pilots, all of whom make too much money anyway. I believe that as every flight is about to depart, an appropriate Flight-Care Council should be formed. It would, of course, include the pilot, whose technical expertise is undeniably required. The council would also include among its members appropriate representatives of the ground crew and the flight crew. The majority of the members, however, should be flight-care consumers, chosen on the basis of a careful consideration of the sexual, ethnic, and religious make-up on the flight in question.

The Flight-Care Council would be responsible for making key policy decisions with respect to the flight, including the time of take-off, the altitude at which the aircraft would fly, where the flight would stop along the way, and the ultimate destination.

After the landing, an Airstrip Utilization Review Committee would make a determination of whether the landing was indeed necessary. In the event that it is deemed to have been unnecessary, the pilot would be forced to take off again.

I urge that our lawmakers speedily enact appropriate legislation that will bring about these long overdue changes in the flight-care system and bring an end to the pilot tyranny that has resulted in maldistribution of flight-care service, unnecessary flights, and lack of attention to the real needs of consumers.

Robert B. Howard, M.D.

Reprinted from The Record, Official Bulletin of the Broward County Medical Association, May 1978.

FLORIDA ASSOCIATION OF GENERAL SURGEONS

ANNUAL INTERIM MEETING

UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE

PRESENTED BY THE DEPARTMENT OF SURGERY
EDWARD R. WOODWARD, M.D., CHAIRMAN

Saturday, September 30, 1978 — 6th Floor Conference Room

APPROVED 6 HRS CATEGORY I CREDIT CME

8:00 a.m. "Peptic Esophagitis and Hiatus Hernia Repair"

10:00 a.m. "Morbid Obesity — Surgical Approach"

12:00 noon Informal Luncheon in Conference Room with Group Discussion

1:00 p.m. "Use of Autostaples in Surgery: Including Lab Experience"

Registration: $25.00 for non-members

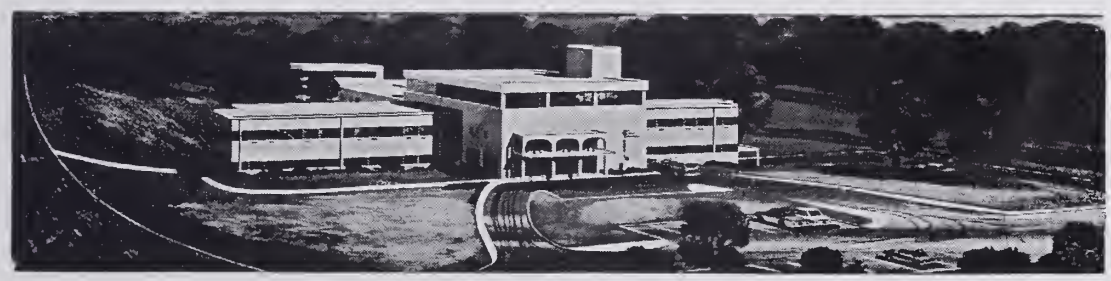
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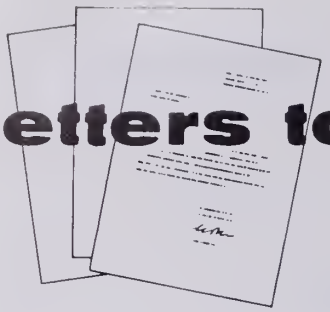
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Letters to the Editors

Dear Editor:

We, the Student Body of the University of Miami School of Medicine, would now like to take this opportunity to thank you for all you have done to make it possible for us to receive your special issue on poisonous plants in Florida.

We would also like to thank the Florida Medical Association's Board of Governors; Ross Laboratories; Laudie McHenry, M.D.; Florida Society of Pathologists and the Florida Pediatric Society for their generous support of medical students in this state and for their continued commitment for excellence in medical education.

Soon after receiving their copies, students commented highly favorably on its quality, depth, and clarity. The fact that it covered a common yet seldom taught medical subject caused many students to regard it as a future reference text in their coming professional lives.

Once again, our heartfelt thanks.

Respectfully yours,

J. Donald Temple, President
University of Miami
Medical School Student Body

President Jimmy Carter
The White House
Washington, D.C.

Dear Mr. President:

As a physician in the private practice of medicine in Florida for the past thirty years and one who has worked actively in the organizations of medicine on a county and state level many of those years, I wish to repudiate your recent public statement that the organizations of medicine are primarily self-seeking. You have been misinformed.

We in this great country enjoy the finest medical care in the world and it is available to the vast majority of our people who seek it. This pre-eminence could not have been achieved by and cannot be maintained by physicians not working in concert which requires an organizational structure, by physicians who are unwilling to give generously of their time in the public's interest, or by lay persons or paid government functionaries however well meaning their intentions. You who espouse the need to return to the concept of individual responsibility should be the last to demean the efforts of the thousands of physicians who daily work without remuneration for the good of the public as well as for their personal patients. Demeaning statements such as your recent utterance can only serve to hurt the cause of good medical care in this country, an act which I don't believe you intend to commit.

William M. Straight, M.D.
Miami

To the Editor: The article by Dr. James F. Richards, Jr. on "Controlling the Cost of Medical Care," focusing on the doctor's responsibility for control and revelation of such care, is long overdue. It takes courage and honesty to challenge x-ray readings, pathologist interpretation, anaesthesiologists overseership, electrocardiography dual review, and even if not continued in this article, why an Aspirin is so expensive when provided in the hospital!

Dr. Richards might have added that doctors insist that their workshop, the hospital, buy the latest in expensive equipment as a rival to another hospital, in the market place "Individualism" of competition, so that they will not lose their patients. This is the economic demand for survival. But it also points up that it is not "Big Brother" who will intervene, but the people supposedly we wish to protect, who will insist that agencies in which they can question, seek data, and rule for or against, will be the determinants. Peer review in hospitals, communities, specialty societies are important, not only as expertise for maintaining standards of practice, aberrations of personality, prodromes of incompetency, and honesty of performance, but as indicator of our being humanists in society, not Druids of unaccountability. Such could be the only level needed to prove our reliability to society. Failure or token participation will certainly result in command take over by other authority.

Harry E. Beller, M.D.
Miami

Dear Dr. Richards: I just read your article relative to controlling the cost of medical care. I remember having seen a somewhat similar article by Dr. Astler about two and a half or three years ago. At that time I thought it was the best editorial I had ever seen.

There are 40 physicians who are working part-time for Vocational Rehabilitation throughout the state. All of these physicians are members of Florida Medical Association and in active private practice in addition to working with Vocational Rehabilitation a few hours each week. I am hoping that all of these district medical consultants of Vocational Rehabilitation have seen your article. To be sure the article was seen, I would very much like to send a copy to each of the medical consultants, and also send a copy to the Vocational Rehabilitation District Supervisors. If you do feel it would be alright to do so, I would make a zerox of the article and send these to the districts. I certainly will not do so without your permission.

During this past month we have distributed several memos to our district offices relative to ways we can reduce our medical expenditures. If we can reduce our expenses, we would be able to serve more clients and increase significantly the number of handicapped individuals who can return to work. I only wish I could convey the message as well as you have.

I realize our medical fees are way out of line and certainly hope this can be converted to more reasonable fees sometime in the near future. However, even after increasing our medical fees, if we do a good job of controlling other costs involved in medical care, we should be able to have reasonable fees for the physicians and at the same time would have more funds to serve a larger number of clients.

At any rate, we certainly would like to send a copy of your article on controlling the cost of medical care to our Vocational Rehabilitation districts.

A. E. Ogden, M.D.
State Medical Consultant
Department of HRS
Tallahassee

Dear Dr. Richards: I have been asked to address the Southern Underwriters Association on April 27th in Orlando, Florida. The topic is to be, "How Doctors Can Help Contribute To Containing The Cost Of Medical Care."

I have received some information from Dr. Parham regarding some of your previous comments on this matter, and, of course, I have read your editorial in the April issue of the *Journal of the Florida Medical Association.*

With your kind permission, I would like to liberally extract material in both of those quotations. I intend, fully, to identify the source and to indicate that the sentiments expressed are those of yourself and the Florida Medical Association. I intend, furthermore, to identify some of the programs that we have instituted, here, in Dade County, specifically at Parkway General Hospital and Jackson Memorial Hospital. My personal philosophy coincides almost completely with that of the Florida Medical Association as expressed in your communication.

I trust that you will have no objection to my utilization of this material.

Julian H. Groff, M.D.
North Miami Beach

To the Editor: This letter is one I promised myself I would write a long time ago but didn't — however, better late than never.

You may recall that you published my scratch board rendering of a Snowy Egret on the cover of *The Journal* in August of 1973. Needless to say, the reproduction has afforded me a continuing pleasure — not only for the personal satisfaction but also because *The Journal* has always recognized other facets of the members besides medicine.

Moreover, I have been pleased to see that you have continued publishing many artistic covers — a most unusual feature for a medical Journal but then I have always thought *The Journal* and the FMA, in general, have given a little extra something to the profession and the public as, for example, the recent series of articles on poisonous plants. The proof is shown in the many complimentary letters you received. After reading the articles, I immediately sent my copy of *The Journal* to my daughter-in-law who is President of the Kingston (N.Y.) Garden Club and one of the official area examiners of flower shows. She was delighted to have it.

Coincidentally, this letter may serve in part to answer your readers survey questionnaire because at 81 and after 15 years' retirement I still take pleasure in receiving and reading *The Journal of the Florida Medical Association.*

Sincerely,

Robert C. Lonergan, M.D.
12559 Palero Road
San Diego, California 92128

Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Autopsy: The Memoirs of Milton Helpern — The World's Greatest Medical Detective by Milton Helpern, M.D. with Bernard Knight, M.D. 272 Pages. Price $10.00. St. Martin's Press, New York, 1977.

As expected from the modest title, this is a collection of anecdotes and cases which purport to show how Dr. Helpern solved everything. Beginning with a thumbnail history of the New York Medical Examiner's Office, we are quickly transported to the Coppolino cases via the bridge over Chappaquiddick Creek. Helpern's recollections, gratuitous legal advice, and criticisms of attorneys' judgments are blatantly self-serving and undocumented. His treatment of other medical experts whose opinions differed from his is discourteous and inaccurate, but posthumous memoirs suffer from that.

The style is chummy while the English is poor. (e.g., on Kopechne's alleged pregnancy: "Well there was no basis for such a conjecture, which no autopsy would have permitted.") The book is easy to read and easier to put down unless the reader has a particular interest in a few sensational murders or the New York M.E.'s Office. Obviously dictated, one wonders whether the author or the editor should be blamed for the rambling, defective style. The historical setting and the wealth of cases called for a cogent, coherent review of this giant's lifelong work in forensic medicine. He was a pioneer and an authority. A loose collection of forensic advice, fragments of New York history and a rambling narrative in the first person is less than he deserved. His co-authored, **Legal Medicine, Pathology and Toxicology** (Appleton-Century-Crofts, N.Y. 1954), while dated, is a fitting monument to the man and his work. The memoirs won't diminish it.

Dr. Helpern appeared for the state and for the defense in numerous trials. His defensive plea for objectivity in the oceanliner death of Lynn Kauffman in 1959 is recounted in sharp contrast to his later, dogmatic opinions for the prosecution in the Coppolino cases in the sixties. Invariably, his conclusions are true, other forensic experts are inept, and opposing lawyers are vindictive. There is no reason to doubt that these were the real opinions of "The Chief" as he was known in his office.

While Helpern erroneously advises that medical examiner's autopsy records are not subject to public inspection (p. 10), he laces his own memoirs with innuendo, accusations and intimate details that should offend survivors and fellow experts alike. Accurate reporting does not require lurid disclosure, but it does require documentation.

I knew Dr. Helpern and admired him. I wish I could recommend his book; however . . .

John R. Feegel, M.D., J.D.
Tampa

Dr. Feegel is a forensic pathologist in Tampa. Dr. Feegel's book entitled "**Autopsy**" was reviewed in the December 1975 issue of the FMA Journal.

Child Health in the Community. A Handbook of Social and Community Pediatrics, edited by Ross G. Mitchell. Price $18.00. Churchill Livingstone, New York, 1977.

This handbook is structured on the central theme, "Health is determined by the interaction between the child, his environment and the society in which he lives, and is not a measurable quantity independent of this relationship."

The contributing authors write in a clear and forthright manner and cover very eloquently the problems of childhood — from fetus to adolescence — without deviating from the central theme.

The major subject headings include: The Child and His Needs; Health Maintenance; Available Child Services, and School Health. The discussions are quite thorough and applicable in principle to conditions in the U.S.A. However, the specifics are based on actual conditions in the United Kingdom with the obvious intent of involving their national health service in recognizing the need for incorporating the concepts of the central theme of this book in its planning.

As would be expected, therefore, the audience for which this book is primarily intended is one of social workers, health visitors, administrators or policymakers in government. Its main value to practicing physicians is to remind us of concepts with which we are familiar and possibly help us organize a more orderly clinical approach to these problems.

Bernard Breiter, M.D.
Bartow

Dr. Breiter is Director, Family Practice Residency Program and Assistant Professor of Family Medicine, University of South Florida, Tampa.

Medical Aspects of the Imported Fire Ant by Robert B. Rhoades, M.D. 75 Pages. Price $4.75. University of Florida Press, Gainesville, 1977.

Recent publicity about invasions of stinging ants and "killer bees" has necessitated a sound scientific treatise such as this. The book consists of five well written and concise chapters. The first, called *The Fascinating World of Ants*, is a highly interesting and readable account of insects in general and bees and ants in particular. The four common fire ant species are described in some detail. The second chapter is entitled *Senses and Communication* and is informative of the physiology of the ant and ant colonies. The first two chapters comprise half the book and reveal Dr. Rhoades's contagious enthusiasm for some of the extraordinary characteristics of the ant world. I found myself having to impart some of these little known facts to anyone around me who would listen.

The third chapter, *Venom*, is the most technical of all the subjects. It contains comparisons of the types of insect venoms as well as information on the fire ant venom itself and its physiological effects. *Clinical Data*, the fourth chapter, describes the characteristics of local and systemic reactions and includes five illustrative case histories. The last chapter is *Prevention and Control* and objectively investigates the problems of various control measures. I would have preferred more emphasis on the modes of action of some of the insecticides, especially Mirex. The author points the way toward the newer and more promising control measures such as hormones, viruses, fungi and bacteria. He does not consider the introduction of anteaters into Florida as a realistic solution. The book ends with a list of 107 references but no index is included.

This appears to be a perfectly sized monograph on the subject and would serve as an excellent introduction to the field of medico-myrmecology.

Michael B. Brodin, M.D.
Clearwater

Dr. Brodin is Clinical Assistant Professor of Medicine, Department of Dermatology, University of South Florida, Tampa.

Register To Vote!

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Labor & Delivery, An Observer's Diary by Constance A. Bean with an introduction by Gerald Cohen, M.D. 203 Pages. Price $7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Clinical Cardiology by Maurice Sokolow, M.D. and Malcolm B. McIlroy, M.D. 659 Pages. Illustrated. Price $16.00. Lange Medical Publications, Los Altos, California, 1977.

Occupational Diseases: A Syllabus of Signs and Symptoms by E. R. Plunkett, M.D. 352 Pages. Price $22.50. The Barrett Book Company, Stamford, Connecticut, 1977.

Current Medical Diagnosis & Treatment by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1098 Pages. Price $17.00. Lange Medical Publications, Los Altos, California, 1978.

DNA Repair Processes, Edited by Warren W. Nichols, M.D. and Donald Murphy, Ph.D. 286 Pages. Illustrated. Price $29.95. Stratton Intercontinental Medical Book Corporation, New York, 1977.

Current Pediatric Diagnosis & Treatment, 5th Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1102 Pages. Illustrated. Price $17.00. Lange Medical Publications, Los Altos, California, 1978.

Chelation Therapy in Chronic Iron Overload, Edited by Edward C. Zaino, M.D. and Richard H. Roberts, M.D. 140 Pages. Illustrated. Price $17.95. Stratton Intercontinental Medical Book Corporation, New York, 1977.

The Health of the People. 140 Pages. Illustrated. Chris van Rensburg Publications (Pty) Ltd., P.O. Box 25272, Ferreirasdorp, 2048, Johannesburg, Republic of South Africa, 1977.

Annual Review of Neuroscience with 28 contributing authors. 506 Pages. Illustrated. Price $17.00. Annual Reviews, Inc., Palo Alto, California, 1978.

Que Paso? An English Spanish Guide for Medical Personnel, Third Edition revised and expanded by Martin P. Kantrowitz, M.D., Antonio Mondragon and William Lord Coleman. 69 Pages. Illustrated. Price $2.95. The University of New Mexico Press, Albuquerque, 1978.

Heart Attack! A Question & Answer Book by Oscar Roth, M.D. with Lawrence Galton. 262 Pages. Price $8.95. Lippincott, New York, 1978.

Pharmacological and Toxicological Perspectives of Commonly Abused Drugs by Darryl Inaba, Ph.D., E. Leong Way, Ph.D., Kenneth Blum, Ph.D. and Sidney H Schnoll, M.D. 44 Pages. National Drug Abuse Center, Rosslyn, Virginia, 1978.



Two University of Miami faculty members . . . have been honored for their work in their specialty areas.

Lynn P. Carmichael, M.D., was selected to receive the first Certificate of Excellence by the Society of Teachers of Family Medicine. Meanwhile, the Florida Academy of Sciences named John E. Davies, M.D., the Outstanding Scientist of Florida for 1978.

Dr. Carmichael, Professor and Chairman of the Department of Family Medicine, was cited for "helping to establish the specialty of Family Medicine, and in gaining recognition for that specialty in medical academia."

The recipient launched the Family Medicine Program at UM in 1965. The program developed into a division and finally a department. It was the first in the nation to offer a Family Practice Residency Program approved by the American Medical Association.

Dr. Davies is Professor and Chairman of the Department of Epidemiology and Public Health. He was cited primarily for his work in the field of pesticides, their composition, effects on man and the environment, and control.

"He has become a foremost authority on the effects of environmental variables upon human biology and health," his citation read. Dr. Davies received a bronze medal at the Academy's annual meeting in Orlando in April.

Bernard L. Kaye, M.D., of Jacksonville . . . has been elected Vice President of the American Society for Aesthetic Plastic Surgery. Dr. Kaye was elected at the Society's 11th Annual Convention in San Francisco, which was attended by more than 600 physicians from the United States and other parts of the world.

Robert L. Simons, M.D., of Miami Beach . . . has been reelected Southern Regional Vice President of the American Academy of Facial Plastic and Reconstructive Surgery. The election of officers was held during the Academy's 14th Annual Meeting at Palm Beach in April.

Florida figured in two awards . . . made in the 1977 Kodak International Newspaper Snapshot Awards.

Certificates of Merit were awarded to Dr. Joe Atchison of Alexandria, Va., and Dr. Sandor A. Levinsohn, a retired physician from Paterson, N.J., now living at West Palm Beach.

Dr. Atchison's prize-winning photograph pictured people and pelicans silhouetted against a setting sun on a fishing pier at Naples. Dr. Levinsohn photographed a small boy with his back turned to the camera in a ghetto area of Paterson.

Catherine Ann Poole, M.D. . . . has been named Chairman of the University of Miami School of Medicine's Department of Radiology and Chief of Radiology Services at Jackson Memorial Hospital and other University-affiliated hospitals.

According to medical school officials, Dr. Poole becomes the first woman to head a medical school radiology department in this country. The appointments were effective on June 1.

Dr. Poole holds the rank of professor in both the radiology and pediatric departments. A graduate of the University of Oregon Medical School, Dr. Poole took a rotating internship and residencies in radiology and pediatric radiology at Jackson and Variety Children's Hospital in Miami.

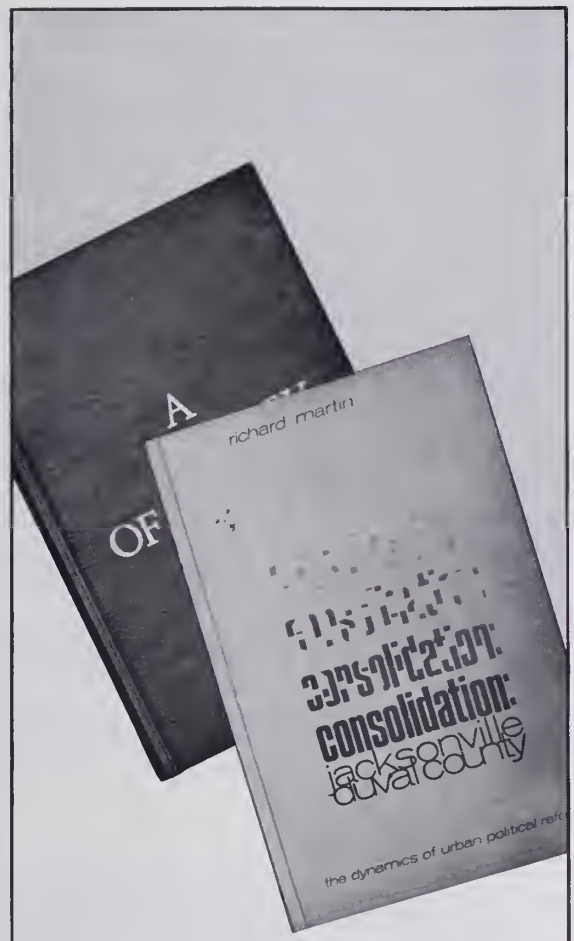
Edward W. D. Norton, M.D., of Miami . . . has been named to a seat on the National Advisory Eye Council. The group advises the National Eye Institute on policy matters and acts as the final recommending authority for applications for research and training grants.

Dr. Norton is Chairman of the Department of Ophthalmology at the University of Miami School of Medicine and also is director of the UM Bascom Palmer Eye Institute and the Anne Bates Leach Eye Hospital.

Alan Zablocki, M.D. . . . former Assistant Editor of *The Journal*, begins his graduate medical training this month at the William Beaumont Army Medical Center in Texas.

Dr. Zablocki received his M.D. degree on June 17 at the University of South Florida College of Medicine. He gained distinction last year when he became the first medical student in the history of the Florida Medical Association to be appointed a voting member of an FMA committee and an Assistant Editor of *The Journal*.

(Editor's note: Dr. Zablocki's former editorial colleagues will miss him but congratulate him on his graduation and extend all best wishes as he embarks on this new phase of his career.)



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Deaths

All, Frank E., Tallahassee; born 1917; Emory University, 1942; member AMA; died February 1, 1978.

Cabre, Gary E., Miami Lakes; born 1943; University of Georgia, 1967; member AMA; died January 2, 1978.

DePoo, Julio J.; Key West; born 1897; University of Havana, 1923; member AMA; died March 23, 1978.

Frye, William K., Bradenton; born 1924; University of Tennessee, 1956; member AMA; died February 11, 1978.

Hamerick, George, Jr., Fort Lauderdale; born 1914; University of Pittsburgh, 1937; member AMA; died January 1978.

Kendrick, Odis G. Jr., Tallahassee; born 1918; Emory University, 1943; member AMA; died February 18, 1978.

Lay, Coy L., Lakeland; born 1923; University of Texas, 1946; member AMA; died January 24, 1978.

Lohrbauer, Leif T., Largo; born 1900; Marquette University, 1927; member AMA; died March 19, 1978.

Minardi, Joseph A., Tampa; born 1904; Loyola University, 1930; member AMA; died April 9, 1978.

Peavy, Henry J., Lake Placid; born 1893; Vanderbilt University, 1916; member AMA; died February 4, 1978.

Ramsey, Russell W., Winter Park; born 1909; Jefferson University, 1937; member AMA; died February 17, 1978.

Rudnick, William H., Sarasota; born 1934; South Carolina Medical School, 1960; member AMA; died February 16, 1978.

Salley, S. Marion, Lake Placid; born 1902; Emory University, 1928; member AMA; died February 16, 1978.

Spoto, Anthony J., Tampa; born 1919; Tulane University, 1943; member AMA; died February 25, 1978.

Stinger, William R., Miami; born 1924; University of Pittsburgh, 1948; member AMA; died February 11, 1978.

Vinson, Clifford E., Fort Myers; born 1912; Loma Linda University, 1941; member AMA; died February 11, 1978.

White, Alvyn W., Pensacola; born 1902; University of Tennessee, 1928; member AMA; died February 9, 1978.

Wood, Rowland E., St. Petersburg; born 1914; Jefferson University, 1940; member AMA; died January 31, 1978.

MEETINGS

Approved by the FMA Committee on Continuing Medical Education

AUGUST

Diagnostic Imaging of the Heart, Aug. 2-6, Hyatt House, Orlando. For information: Lawrence R. Muroff, M.D., P.O. Box 17241, Tampa 33682.

Clinical Electrocardiography and Arrythmia Management, Aug. 11-13, Hyatt House, Orlando. For information: William E. James, Ph.D., 64 Inverness Drive, Englewood, Colorado 80110.

Initial Management of the Pediatric Emergency, Aug. 23-27, Playboy Resort Hotel, Lake Geneva, Wisconsin. For information: Emergency Medical Services Symposia, Inc., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

Laparoscopy Course, Aug. 28-29, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

SEPTEMBER

South East Pediatric Educational Conference of Florida, Sept. 2-4, Cape Eleuthera, Bahamas. For information: Gerald T. Kilpatrick, M.D., 531 U.S. Highway #1, North Palm Beach, Florida 33408.

Transient Ischemic Attacks: The Computerized EEG, September 11, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.

Fifth Annual Cardiovascular Symposium, Sept. 14-15, Hilton Inn, Gainesville. For information: Howard W. Ramsey, M.D., P. O. Box 13494, Gainesville 32604.

Anesthesiology Review and Update, Sept. 15-17, Sonesta Beach Hotel, Key Biscayne. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Sexual Medicine, Sept. 18, Sheraton Riverhouse Hotel, Miami. For information: Domeena C. Renshaw, M.D., 2160 South 1st Ave., Maywood, Illinois 60153.

Clinical Family Planning for Physicians, Sept. 18-19, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Pneumoccal Pneumonia and Polysaccharide Vaccines, Sept. 21, Pan American Hospital, Miami. For information: Hilario Anido, M.D., 5959 Northwest 7th Street, Miami, Florida 33126.

Laparoscopy Course, Sept. 25-26, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

OCTOBER

Current Concepts in Neurology, Oct. 12-14, Doral Country Club, Miami. For information: Allan Herskowitz, M.D., 155 Northwest 167th St.; North Miami Beach 33169.

Obstetrics and Gynecology Review Course, Oct. 21-Nov. 1, Royal Biscayne Beach Hotel and Racquet Club, Key Biscayne.*

Laparoscopy Course, Oct. 25-26, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

NOVEMBER

Thromboembolism and Thrombolytic Therapy, Nov. 2, Mount Sinai Medical Center, Miami Beach. For information: Marvin L. Meitus, M.D., 4300 Alton Road, Miami Beach, Florida 33140.

Medicine in Maturity (Geriatric Medicine), Nov. 8-12, Don CeSar Hotel, St. Petersburg Beach. For information: American Medical Women's Association, 1740 Broadway, New York, New York 10019.

Adolescent Medicine, Nov. 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Clinical Family Planning for Physicians, Nov. 13-14, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Laparoscopy Course, Nov. 13-14, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Florida Endocrine Society's Fall Meeting, Nov. 18-19, The Colony Beach & Tennis Resort, Sarasota. For information: Yank D. Coble Jr., M.D., 2700 Riverside Avenue, Jacksonville 32205.

DECEMBER

7th Annual Refresher Course for Nurse Anesthetists, Dec. 1-3, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Glaucoma Symposium, Dec. 7-9, University of South Florida Medical Center, Tampa. For information: W. E. Layden, M.D., P.O. Box 21, MDC, University of South Florida, Tampa 33612.

Cardiac Symptoms and Arrhythmias — Their Diagnosis and Treatment, Dec. 8-10, Americana of Bal Harbour, Miami. For information: IMEC, 64 Inverness Drive East, Englewood Colorado 80110.

Coronary Disease, Exercise Testing, and Cardiac Rehabilitation, Dec. 8-10, Konover Hotel, Miami. For information: IMEC, 64 Inverness Drive East, Englewood, Colorado 80110.

Laparoscopy Course, Dec. 11-12, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

1979

FEBRUARY

Second Symposium on Neurological Surgery of the Ear, Feb. 3-8, Sarasota. For information: Ms. Susan G. Brown, 1845 Hillview Street, Sarasota 33579.

***For information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

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SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS Associate	Active
Alachua	James C. Garlington, Gainesville	Orvin Jenkins, Gainesville	2nd Tues.	89	284
Baker (See Nassau)					
Bay	John P. Capp, Panama City	Rush E. Akin, Panama City	1st Tues.	0	66
Bradford (See Alachua)					
Brevard	Burton Podnos, Rockledge	Francis S. Pooser, Melbourne	2nd Tues.	28	226
Broward	Arthur L. Eberly, Lighthouse Point	William C. Hartley, Hollywood	4th Tues.	125	1,224
Calhoun (See Panhandle)					
Capital	Jesse L. Judelle, Tallahassee	Howard G. Armstrong, Tallahassee	2nd Mon.	30	188
Charlotte	Stanley I. Spoont, Punta Gorda	Stephen R. Roddy, Charlotte Harbor	3rd Mon.	7	78
Citrus-Hernando	Marshall E. Smith, Brooksville	Jose R. Berrios, Brooksville	3rd Thurs.	1	47
Clay	Richard J. Bultman, Orange Park	A. David Thaeler, Penney Farms	2nd Thurs.	4	39
Collier	Charles S. Eytel, Naples	Richard J. Cavallaro, Naples	3rd Wed.	0	96
Columbia	Jose Goyenechea, Lake City	D. D. Weiffenbach, Lake City	3rd Wed.	1	27
Dade	Sol Center, Miami	Sheldon Zane, N. Miami Beach	1st Tues.	286	2,683
DeSoto-Hardee-Glades	Clark H. Adair, Arcadia	Leo D. Bonagua, Arcadia	1st Tues.	8	20
Dixie (See Taylor)					
Duval	Robert K. Middlekauff, Jacksonville	Faris S. Monsour, Jacksonville	1st Tues.	130	695
Escambia	George L. Carr, Pensacola	Paul T. Baroco, Pensacola	2nd Tues.	43	249
Flagler (See St. Johns)					
Franklin-Gulf	J. Wayne Hendrix, Port St. Joe	W. T. Weathington, Apalachicola	Last Wed.	0	10
Gadsden (See Panhandle)					
Gilchrist (See Alachua)					
Hendry (See Palm Beach)					
Highlands	Richard R. Martin, Avon Park	James P. Satterwhite, Avon Park	3rd Mon.	0	49
Hillsborough	Richard S. Hodes, Tampa	Jeff W. Harris, Tampa	1st Tues.	114	654
Holmes (See Panhandle)					
Indian River	Donald L. Ames, Vero Beach	Paul A. Graham, Vero Beach	3rd Tues.	9	70
Jackson (See Panhandle)					
Jefferson (See Capital)					
Lake	Tully C. Patrowicz, Mount Dora	Thomas S. Techman, Leesburg	1st Wed.	0	94
Lee	Warren E. Hagen, Ft. Myers	Philip M. Payne, Ft. Myers	3rd Mon.	26	195
Leon (See Capital)					
Levy (See Marion)					
Liberty (See Panhandle)					
Madison	William J. Bibb, Madison	Julian M. DuRant, Madison	1st Tues.	2	6
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Nassau	Jose L. Castillo, Fernandina Beach	Cecil B. Brewton, Fernandina Beach	3rd Thurs.	3	18
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Panhandle	Richard H. Schulz, Marianna	William F. Brunner, Marianna	1st Thurs.	4	56
Pasco	G. William Lazenby, Tarpon Springs	Nessan McCann, Holiday	2nd Thurs.	22	53
Pinellas	William F. Mallette, St. Petersburg	Thomas M. Daniel, Clearwater	1st Mon.	146	674
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Sumter (See Citrus-Hernando)					
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Taylor	John H. Parker, Perry	John A. Dyal, Perry	Last Mon.	0	12
Union (See Alachua)					
Volusia	James G. White, Ormond Beach	William R. Jones, Daytona Beach	2nd Tues.	2	241
Wakulla (See Capital)					
Walton	Thomas G. Spence, DeFuniak Springs	Edgar H. Myers, DeFuniak Springs	2nd Tues.	0	6
Washington	Norbert J. Wegmann, Chipley	Henry A. Knowles, Chipley	3rd Tues.	0	7
			Total	1,387	10,509
			Grand Total		11,896

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The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V. inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest, concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea, have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures, use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

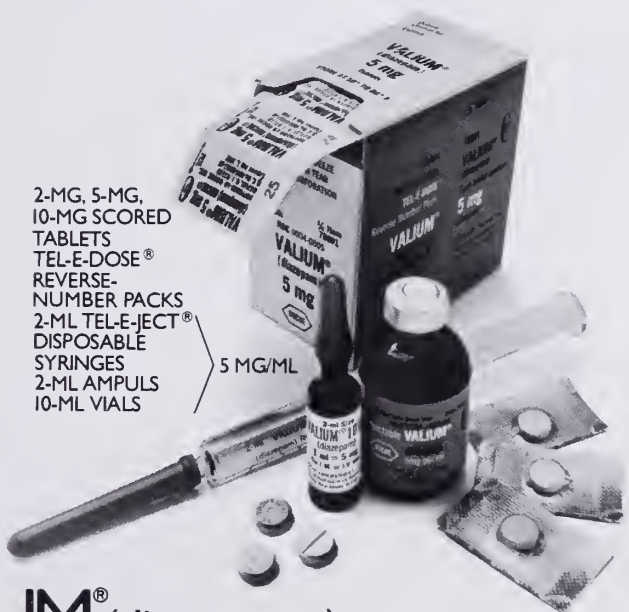
In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

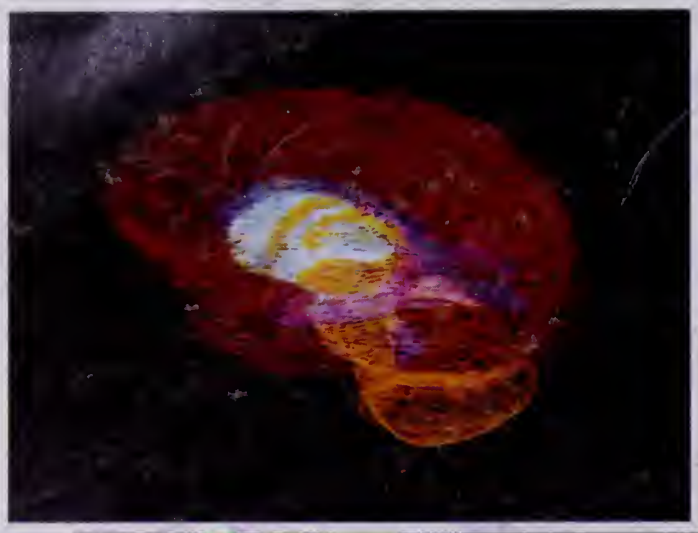
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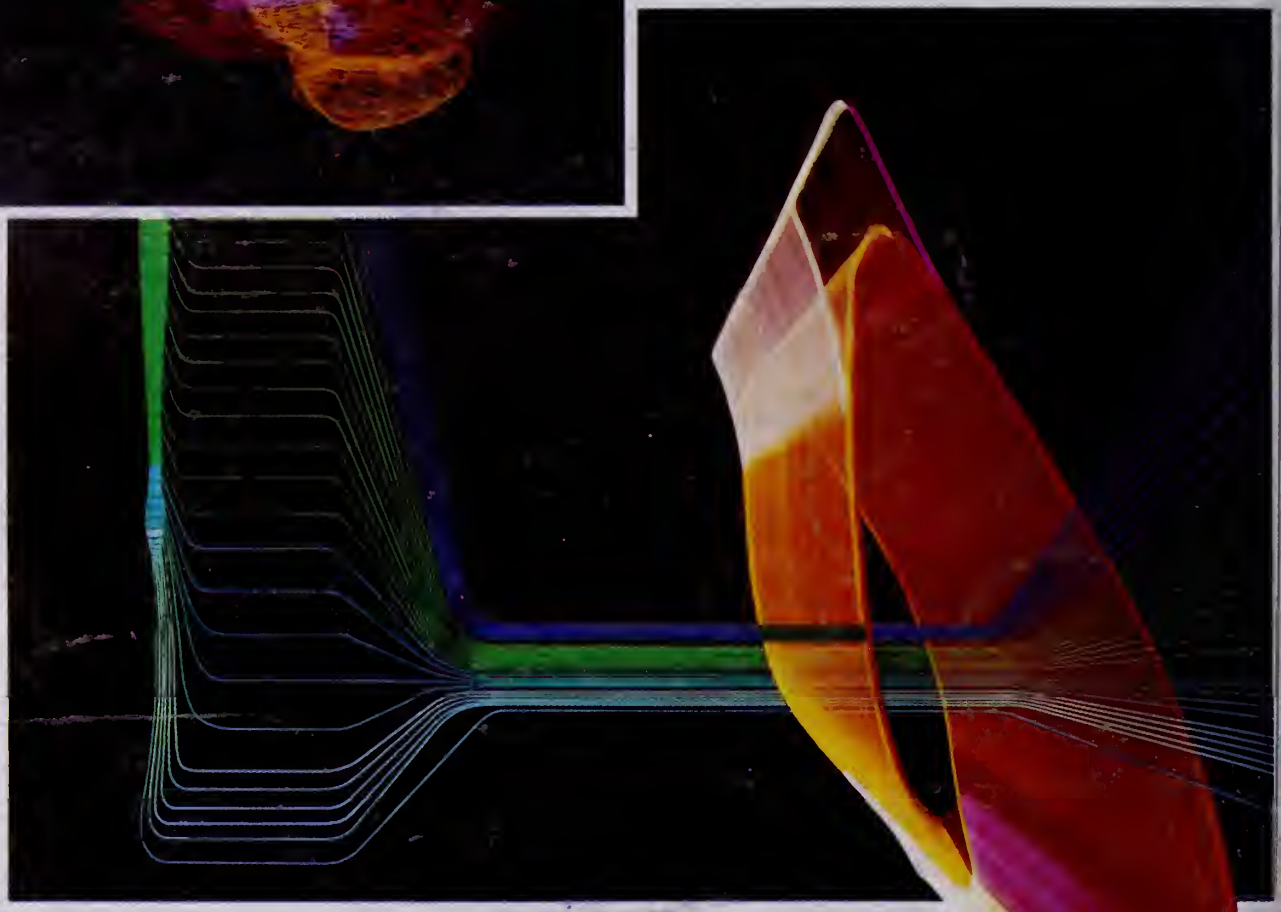


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ding page for a summary of product information.

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AUGUST 1978 • VOL 65 • NO 8



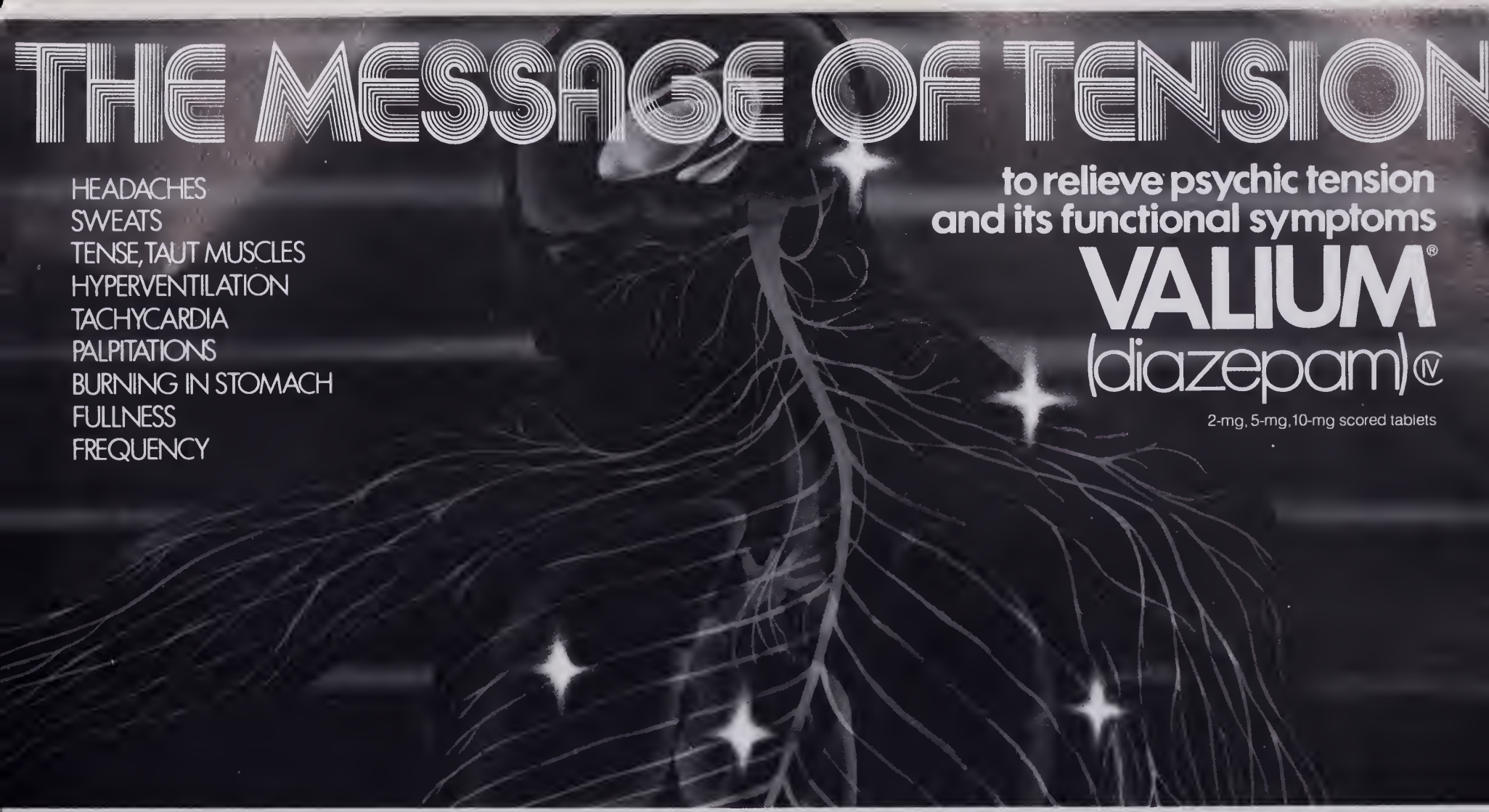
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Historical Issue

William M. Straight, M.D.

Guest Editor

MDS



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Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Adverse Reactions: Drowsiness, fatigue, confusion, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Can you have too much of a good thing?

Too much milk, many pediatricians warn, can fill a child up and consequently, can keep him from eating other foods he needs. Particularly, iron-rich foods.

And, of course, that's a major dietary concern.

But you can also have too little of a good thing. Especially, milk. Milk supplies more essential nutrients per calorie than most other foods.

A child between the ages of six months and six years, for example, can get at least three-fourths of his daily dietary allowance for calcium, riboflavin, vitamins D and B_{12}, phosphorus, and protein from just three glasses of milk. And milk is also a good source of vitamins A and B_6, as well as thiamin and niacin.

That's why the U.S.D.A., acting on the recommendation of the National Research Council—National Academy of Sciences, has established these guidelines for milk consumption:

Children up to 6 years
Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on: 60 mg tryptophan=1 mg niacin

ndc **National Dairy Council**

Milk. Sometimes we forget all the good things it does.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION INC
AUGUST 1978 • VOL 65 • NO 8

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AUGUST COVER — Nineteenth century bleeding and cupping instruments with case belonging to George Curtis Austin, M.D., Miami. Photography by Charles Bailey, University of Miami Department of Medical Photography.



President's Page

A Tribute to Dr. Straight

Historians are among the most respected of all scholars. Certainly Dr. William M. Straight, our "in-house historian" and Historical Editor of *The Journal*, is one of our most respected scholars and practitioners of medicine.

For 13 years his articles and the articles of his selected contributors have constituted the principal part of our August issues of *The Journal*. He recently spent two weeks in Washington, D.C., researching his current article on medicine during the Seminole Wars (See Page 627).

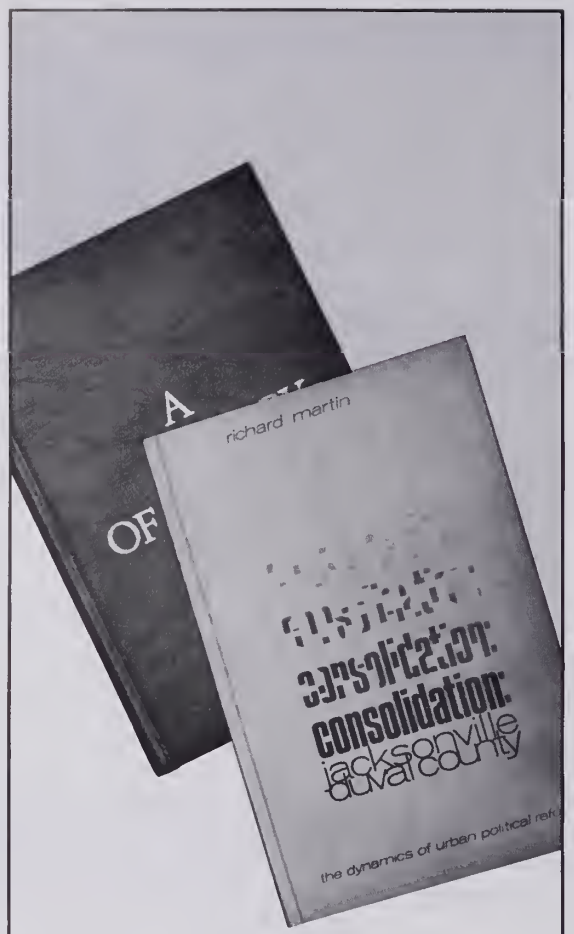
Why is Bill so interested in history? He likes to find out "how things got that way." And he also finds peace and contentment in the study of less complex times. Some of Bill's favorite quotations are as follows:

> *Medicine, like all knowledge, has a past as well as a present and a future . . . and in that past is the indispensable soil out of which improvement must grow." — **Alfred Still***
>
> *The use of history is to give value to the present hour and its duty. — **Emerson***
>
> *The best that history has to give us is the enthusiasm which it arouses. — **Goethe***

We in Florida Medicine are deeply indebted to Bill and sincerely hope that his enthusiasm continues and even becomes contagious. Efforts are being made to interest him in developing sketches of all physicians who have contributed to the development of our territorial and state governments from their origin to the present.

Next August?

O. Wm. Davenport M.D.



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Brief Summary of Prescribing Information
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Capsules and Oral Solution
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

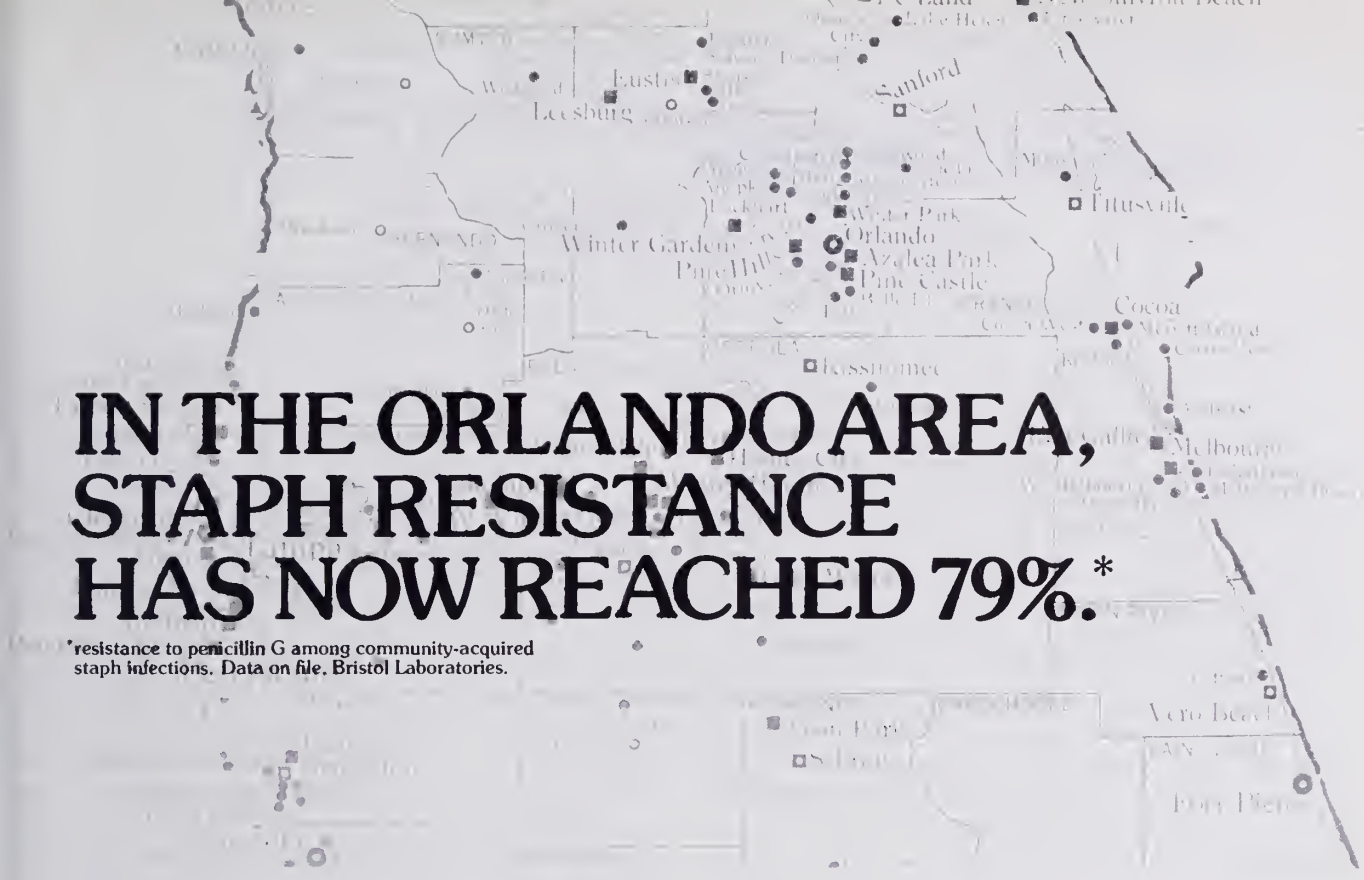
Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

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*resistance to penicillin G among community-acquired staph infections. Data on file. Bristol Laboratories.

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(cloxacillin sodium)

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‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary for prescribing information.

Dean's Page

Public Law 92-063 Section 227

E. M. Papper, M.D.

The Social Security amendments of 1972 (Public Law 92-063) contain a provision (Section 227) pertaining to reimbursement to physicians in a teaching setting for services rendered to Medicare patients. The law provides standards which must be met in order for the teaching physician to be reimbursed on a fee-for-service basis. If the standards are not met, then the physician is to be reimbursed on the basis of "reasonable costs."

For the past several years, the Association of American Medical Colleges and others have successfully convinced the Congress to delay the implementation of Section 227. This strategy is evidently no longer possible. It now appears that Section 227 will be instituted beginning October 1, 1978.

Unfortunately, the enforcement of this law could have gravely adverse effects on medical schools throughout the nation. At best, it could create an administrative nightmare in order to meet the fiscal test; at the worst, it could cause serious financial difficulties. It also brings clinical medical school faculty even closer to their colleagues in private practice. The physician in private practice will certainly lose his fee-for-service relationship with patients sooner rather than later.

For the past several months, the Bureau of Health Care Financing Administration of the Department of Health Education and Welfare has been drafting the regulations which will implement Section 227. They are now in the Office of the Chief Counsel for the Department of HEW. We have been advised that they should be published in the Federal Register shortly.

We have received information supporting the probability that the proposed regulations will require that 85% of the patients in a teaching hospital meet the definition of a private patient. In addition, the teaching physicians must meet a fiscal test, which requires that they be able to demonstrate that they have collected 80% of the charges from at least 50% of their non-Medicare patients, in order to qualify for reimbursement on a fee-for-service basis.

These requirements are almost impossible to meet for those medical centers serving areas where a substantial percentage of the patients are financially or medically indigent. There are many responsible people who feel that this harsh approach is a push for nationalization of health care by insurance or other means.

Many medical schools that are providing a significant volume of service to Medicare patients now depend upon income derived from services to these patients for the support of medical education and research. If these fee-for-service funds are now discontinued, it is conceivable that many highly skilled physicians who presently provide these services will be unwilling to care largely for the indigent while their colleagues in practice care only for the more affluent. Some will leave academic medicine for private practice, and simultaneously seriously weaken schools of medicine and produce an overflow of unneeded physicians in the largely urban communities which will be affected.

Over the past decade, many teaching hospitals have eliminated the old system of two standards of care, one for private patients and one for indigent patients. The implementation of Section 227, as presently contemplated, could also lead to a restoration of the old system of a dual standard of care and drive downward all the gains that the poor have rightfully achieved.

I believe that a more realistic and healthy approach would be to continue the rules presently in effect, which require a teaching physician to provide personal and identifiable care to each Medicare patient in order to bill for his professional services. If he is unwilling or unable to provide this kind of service, then funds should not be collectible from Medicare.

One more instance of overregulation of our society is at hand. This one could severely injure the health care of the poor and near poor and simultaneously cripple medical education. If it prevails, it may be a crowning achievement of destruction by those who should know better.

Dr. Papper is Vice President for Medical Affairs and Dean, University of Miami School of Medicine, Miami.

● Dr. Papper, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152.

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†See Prescribing Information

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erious as well as minor side effects have been reported with the use of oral contraceptives. These include
romboembolic disease. The physician should remain alert to the earliest manifestations of any
mptoms of serious disease and discontinue oral contraceptive therapy when appropriate. The physician
ould be fully aware of the complete Prescribing Information for this product.

ee the complete Prescribing Information for this product,
summary of which is on the next page.

Ortho Pharmaceutical Corporation 1978

OJ 1291

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IMPORTANT NOTE—This information is a BRIEF SUMMARY of the complete prescribing information provided with the product and therefore should not be used as the basis for prescribing the product. This summary was prepared by deleting from the complete prescribing information certain text, tables, and references. The physician should be thoroughly familiar with the complete prescribing information and patient information before prescribing the product.

INDICATION: CONTRACEPTION. The pregnancy rate in women using conventional combination oral contraceptives (containing 35 mcg or more of ethinyl estradiol or 50 mcg or more of mestranol) is generally reported as less than one pregnancy per 100 woman-years of use. Slightly higher rates (somewhat more than one pregnancy per 100 woman-years of use) are reported for some combination products containing 35 mcg or less of ethinyl estradiol, and rates on the order of three pregnancies per 100 woman-years are reported for the progestogen-only oral contraceptives. Table 1 gives ranges of pregnancy rates reported in the literature for other means of contraception. The efficacy of these means of contraception (except the IUD) depends upon the degree of adherence to the method.

Table 1: Pregnancies Per 100 Women-Years. IUD, less than 1-6; Diaphragm with spermicidal product (creams or jellies), 2-20; Condom, 3-36; Aerosol foams, 2-29, Jellies and creams, 4-36; Periodic abstinence (rhythm) all types, less than 1-47; 1. Calendar method, 14-47; 2. Temperature method, 1-20; 3. Temperature method—intercourse only in postovulatory phase, less than 1-7; 4. Mucus method, 1-25; No contraception, 60-80. **DOSE-RELATED RISK OF THROMBOEMBOLISM FROM ORAL CONTRACEPTIVES:** Two studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. For this reason, it is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive product prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance. It is recommended that new acceptors of oral contraceptives be started on preparations containing .05 mg or less of estrogen. **CONTRAINDICATIONS:** Oral contraceptives should not be used in women with any of the following conditions: 1. Thrombophlebitis or thromboembolic disorders. 2. A past history of deep vein thrombophlebitis or thromboembolic disorders. 3. Cerebral vascular or coronary artery disease. 4. Known or suspected carcinoma of the breast. 5. Known or suspected estrogen-dependent neoplasia. 6. Undiagnosed, abnormal genital bleeding. 7. Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic. These studies estimate that users of oral contraceptives are 4 to 11 times more likely than nonusers to develop these diseases without evident cause. Overall excess mortality due to pulmonary embolism or stroke is on the order of 1.0 to 3.5 deaths annually per 100,000 users and increases with age. **CEREBROVASCULAR DISORDERS:** In a collaborative American study of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than in nonusers and the risk of thrombotic stroke was 4.0 to 9.5 times greater in users than in nonusers.

MYOCARDIAL INFARCTION: An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported confirming a previously suspected association. These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor. The annual excess case rate (increased risk) of myocardial infarction (fatal and nonfatal) in oral contraceptive users was estimated to be approximately 7 cases per 100,000 women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group. In terms of relative risk, it has been estimated that oral contraceptive users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are also smokers have about a 5-fold increased risk of fatal infarction compared to users who do not smoke, but about a 10-to 12-fold increased risk compared to nonusers who do not smoke. Furthermore, the amount of smoking is also an important factor. In determining the importance of these relative risks, however, the baseline rates for various age groups must be given serious consideration. The importance of other predisposing conditions mentioned above in determining relative and absolute risks has not as yet been quantified; it is quite likely that the same synergistic action exists, but perhaps to a lesser extent. **Risk of Dose:** In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives. Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 50-80 mcg of estrogen. Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved. This finding has been confirmed in the United States. Careful epidemiological studies to determine the degree of thromboembolic risk associated with progestogen-only oral contraceptives have not been performed. Cases of thromboembolic disease have been reported in women using these products, and they should not be presumed to be free of excess risk. The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age. Oral contraceptives are, however, an independent risk factor for these events. **ESTIMATE OF EXCESS MORTALITY FROM CIRCULATORY DISEASES:** A large prospective study carried out in the United Kingdom estimated the mortality rate per 100,000 women per year from diseases of the circulatory system for users and nonusers of oral contraceptives according to age, smoking habits, and duration of use. The overall excess death rate annually from circulatory diseases for oral contraceptive users was estimated to be 20 per 100,000 (ages 15-34—5/100,000; ages 35-44—33/100,000; ages 45-49—140/100,000), the risk being concentrated in older women, in those with a long duration of use, and in cigarette smokers. It was not possible, however, to examine the interrelationships of age, smoking, and duration of use, nor to compare the effects of continuous versus intermittent use. Although the study showed a 10-fold increase in death due to circulatory diseases in users for five or more years, all of these deaths occurred in women 35 or older. Until larger numbers of women under 35 with continuous use for five or more years are available, it is not possible to assess the magnitude of the relative risk for this younger age group. This study reports that the increased risk of circulatory diseases may persist after the pill is discontinued. Another study published at the same time confirms a previously reported increase of mortality in pill users from cardiovascular disease. The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception. The estimates of risk of death for each method include the combined risk of the contraceptive method (e.g., thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure. This latter risk varies with the effectiveness of the contraceptive method. The findings of this analysis are shown in Figure 1 below. The study concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke. (The rates given for pill only/smokers for each age group are for smokers as a class. For "heavy" smokers [more than 15 cigarettes a day], the rates given would be about double; for "light" smokers [less than 15 cigarettes a day], about 50 percent.) The mortality associated with oral contraceptive use in nonsmokers over 40 is higher than with any other method of contraception in that age group. The lowest mortality is associated with the condom or diaphragm backed up by early abortion. The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia and especially by cigarette smoking. The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors. The use of oral contraceptives in women in this age group is not recommended. Based on the data currently available, the following chart gives a gross estimate of the risk of death from circulatory disorders associated with the use of oral contraceptives:

SMOKING HABITS AND OTHER PREDISPOSING CONDITIONS—RISK ASSOCIATED WITH USE OF ORAL CONTRACEPTIVES

Age	Below 30	30-39	40+	
Heavy smokers	C	B	A	A—Use associated with very high risk
Light smokers	D	C	B	B—Use associated with high risk.
Nonsmokers (no predisposing conditions)	D	C,D	C	C—Use associated with moderate risk.
Nonsmokers (other predisposing conditions)	C	C,B	B,A	D—Use associated with low risk.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e.g., thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately. A four- to six-fold increased risk of postsurgery thromboembolic complications has been reported in oral contraceptive users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization. 2. OCULAR LESIONS. There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives. Discontinue oral contraceptive medication if there is unexplained, sudden or gradual, partial or complete loss of vision; onset of proptosis or diplopia; papilledema; or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures. 3. CARCINOMA. Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver. Certain synthetic progestogens, none currently contained in oral contraceptives, have been noted to increase the incidence of mammary nodules, benign and malignant, in dogs. In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives. Of the cases found in women without predisposing risk factors for adenocarcinoma of the endometrium (e.g., irregular bleeding at the time oral contraceptives were first given, polycystic ovaries), nearly all occurred in women who had used a sequential oral contraceptive. These products are no longer marketed. No evidence has been reported suggesting an increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives. Several studies have found no increases in breast cancer in women taking oral contraceptives or estrogens. One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in the subgroups of oral contraceptive users with documented benign breast disease. A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented. In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of all women taking oral contraceptives is, nevertheless, essential. In all cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception.

Figure 1. Estimated annual number of deaths associated with control of fertility and no control per 100,000 nonsterile women, by regimen of control and age of woman.

	15-19	20-24	25-29	30-34	35-39	40-44
No method	5.5	5.2	7.1	14.0	19.3	21.9
Abortion only	2.3	2.5	2.5	5.2	9.8	6.6
Pill only-nonsmokers	1.3	1.4	1.4	2.2	4.5	3.1
Pill only-smokers	1.5	1.6	1.6	10.8	13.4	58.9
IUDs only	1.1	1.2	1.2	1.4	1.6	1.4
Traditional contraception only	1.1	1.4	1.9	3.7	4.7	4.0
Traditional contraception and abortion	0.3	0.4	0.4	0.8	1.4	0.8

4. HEPATIC TUMORS. Benign hepatic adenomas have been found to be associated with the use of oral contraceptives. One study showed that oral contraceptive formulations with high hormonal potency were associated with a higher risk than lower potency formulations. Although benign, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage. This has been reported in short-term as well as long-term users of oral contraceptives. Two studies relate risk with duration of use of the contraceptive, the risk being much greater after four or more years of oral contraceptive use. While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass or shock. A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time. 5. **USE IN OR IMMEDIATELY PRECEDING PREGNANCY, BIRTH DEFECTS IN OFFSPRING, AND MALIGNANCY IN FEMALE OFFSPRING.** The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated to be on the order of 1 to 4 in 1000 exposures. Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception. Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy. Male children so exposed may develop abnormalities of the urogenital tract. Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes. An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of sex hormones, including oral contraceptives, in pregnancy. One case control study has estimated a 4.7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal withdrawal tests for pregnancy or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 live births. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives. Embryos with these anomalies are virtually always aborted spontaneously. Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown. Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks. It is also recommended that women who discontinue oral contraceptives with the intent of becoming pregnant use an alternate form of contraception for a period of time before attempting to conceive. Many clinicians recommend three months although no precise information is available on which to base this recommendation. The administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy. 6. GALLBLADDER DISEASE. Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives and estrogens. In one study, an increased risk appeared after two years of use and doubled after four or five years of use. In one of the other studies, an increased risk was apparent between six and twelve months of use. 7. CARBOHYDRATE AND LIPID METABOLIC EFFECTS. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives. An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives. 8. ELEVATED BLOOD PRESSURE. An increase in blood pressure has been reported in patients receiving oral contraceptives. In some women hypertension may occur within a few months of beginning oral contraceptive use. In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers. The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year. Age is also strongly correlated with the development of hypertension in oral contraceptive users. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives. Hypertension that develops as a result of taking oral contraceptives usually returns to normal after discontinuing the drug. 9. HEADACHE. The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause. 10. BLEEDING IRREGULARITIES. Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind. In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy. If pathology has been excluded, time or a change to another formulation may solve the problem. Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since it may increase the risk of thromboembolic disease. Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives. Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods. Postuse anovulation, possibly prolonged, may also occur in women without previous irregularities. 11. ECTOPIC PREGNANCY. Ectopic as well as intrauterine pregnancy may occur in contraceptive failures. 12. BREAST FEEDING. Oral contraceptives given in the postpartum period may interfere with lactation. There may be a decrease in the quantity and quality of the breast milk. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The effects, if any, on the breast-fed child have not been determined. If feasible, the use of oral contraceptives should be deferred until the infant has been weaned. **PRECAUTIONS: General:** 1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As with general rule, oral contraceptives should not be prescribed for longer than one year without another physical examination being performed. 2. Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size. 3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree. Patients becoming significantly depressed while taking oral contraceptives should stop the medication and use an alternate method of contraception in an attempt to determine whether the symptom is drug-related. 4. Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, asthma, or cardiac or renal insufficiency. 5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy. If jaundice develops in any patient receiving such drugs, the medication should be discontinued. 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients. 7. Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency. 8. Serum folate levels may be depressed by oral contraceptive therapy. Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency. 9 The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted. 10. Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives: a. Increased sulfobromophthalein retention. b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. c. Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered. d. Decreased pregnanediol excretion. e. Reduced response to metyrapone test. **INFORMATION FOR THE PATIENT: (See Patient Package Insert). DRUG INTERACTIONS:** Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin. **CARCINOGENESIS, PREGNANCY, NURSING MOTHERS: See CONTRAINDICATIONS and WARNINGS. ADVERSE REACTIONS:** An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see WARNINGS): Thrombophlebitis. Pulmonary embolism. Coronary thrombosis. Cerebral thrombosis. Cerebral hemorrhage. Hypertension. Gallbladder disease. Liver tumors. Congenital anomalies. There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: Mesenteric thrombosis. Neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis. The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug-related. Nausea, usually the most common adverse reaction. Vomiting, occurs in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally. Gastrointestinal symptoms (such as abdominal cramps and bloating). Breakthrough bleeding. Spotting. Change in menstrual flow. Dysmenorrhea. Amenorrhea during and after treatment. Temporary infertility after discontinuance of treatment. Edema. Chloasma or melasma which may persist. Breast changes: tenderness, enlargement, and secretion. Change in weight (increase or decrease). Change in cervical erosion and cervical secretion. Possible diminution in lactation when given immediately postpartum. Cholestatic jaundice. Migraine. Increase in size of uterine leiomyomata. Rash (allergic). Mental depression. Reduced tolerance to carbohydrate. Vaginal candidiasis. Change in corneal curvature (steepening). Intolerance to contact lenses. The following adverse reactions have been reported in users of oral contraceptives, and the association has been neither confirmed nor refuted: Premenstrual-like syndrome. Cataracts. Changes in libido. Chorea. Changes in appetite. Cystitis-like syndrome. Headache. Nervousness. Dizziness. Hirsutism. Loss of scalp hair. Erythema multiforme. Erythema nodosum. Hemorrhagic eruption. Vaginitis. Porphyria. Impaired renal function. (ORTHO-NOVUM 1/50□21 and ORTHO-NOVUM 1/50□28 contain tartrazine.) Allergic reactions have been reported with the ingestion of this dye in some patients.) **ACUTE OVERDOSE:** Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females.

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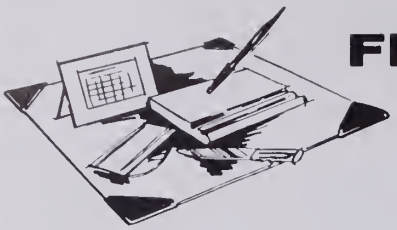


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FROM THE EDITOR'S DESK

FMA MEDICARE SUIT

As this issue of *The Journal* went to press, a final federal court ruling was believed imminent in the Florida Medical Association's fight to prevent the Department of HEW from releasing 1977 Medicare payment data on physicians. Since the litigation began, U.S. District Judge Charles Scott of Jacksonville has granted four temporary restraining orders, two of them since the American Medical Association joined the FMA suit as an intervening plaintiff. HEW had planned to release payment information throughout the country about April 30, but these plans were crimped when FMA and other medical organizations went to court. The next significant step is expected to be Judge Scott's decision on whether to grant FMA a permanent injunction.

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DR. HODES ELECTED

Richard S. Hodes, M.D., of Tampa, President-Elect of the Florida Medical Association, has been elected Vice President of the National Conference of State Legislatures. Dr. Hodes is Speaker Pro Tem-designate of the Florida House of Representatives, in which he has served for many years. He was elected to the vice presidency during the Conference's Annual Meeting in Denver, which was attended by about 2,300 state legislators from throughout the United States. Dr. Hodes is one of 36 medical family members holding senate or house seats in 24 states.

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REP. ROGERS RETIRING

Congressman Paul Rogers of West Palm Beach caught everyone, including his closest associates, by surprise when he announced in June that he will not seek re-election. As Chairman of the House Commerce Subcommittee on Health, the 57-year-old Rogers is one of the most influential individuals in the shaping of national health legislation. "I just think it's time to do something different," he said in announcing his approaching retirement after 24 years in Congress. In 1976, Mr. Rogers was the fourth recipient of FMA's Distinguished Layman Award.

AMA PRESIDENT

Despite a well-organized campaign by Florida physicians and their wives, Jere W. Annis, M.D., of Lakeland, fell short of the number of votes he needed to be elected President-Elect of the American Medical Association. Hoyt Gardner, M.D., of Louisville, Ky., was the choice of AMA House of Delegates members in the balloting in St. Louis, Mo., on June 22. Dr. Annis' loss was generally attributed to his late entry into the campaign. In brief remarks to the House of Delegates, Dr. Annis congratulated and praised Dr. Gardner and said farewell to the AMA Board of Trustees and House of Delegates which he had served for many years.

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NEW AMA PRESIDENT

Tom E. Nesbitt, M.D., of Nashville, Tenn., was installed as the AMA President at the St. Louis meeting. In his inaugural address, Dr. Nesbitt urged AMA members to "voluntarily restrain the rate of professional fee increases." The trend in the rate of fee increases is already downward, he said. The 1977 rate of increase was 9.2%, which is 4% below the rate in the year immediately following the end of federal price controls.

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HEALTH CARE COSTS

The AMA House of Delegates spent much of its working time in St. Louis on cost containment. The massive report of the AMA-sponsored National Commission on the Cost of Medical Care required 56 official actions. The House endorsed 29 of the 48 recommendations of the Commission. Two recommendations pertaining to peer review and defensive medicine were referred to a special committee to be composed of representatives of AMA Councils and Committees.

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NATIONAL HEALTH INSURANCE

Four powerful Senators have lined up in support of a new National Health Insurance bill that has developed in

Congress. The bill, similar to last year's Long-Ribicoff bill, would establish a catastrophic program to cover all citizens after they had incurred medical expenses of $2,000 or had been hospitalized for 60 days. The program would be financed by a 1% payroll tax on employers, and employers could choose a private health insurance plan or a federal program using carriers as in the present Medicare program. The bill has the backing of Senate Finance Chairman Russell Long of Louisiana, Finance Health Subcommittee Chairman Herman Talmadge of Georgia, and Senators Abraham Ribicoff of Connecticut and Robert Dole of Kansas.

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ADMINISTRATION'S NHI BILL

Meanwhile, an intensive and expensive campaign to sell the public on the Carter Administration's National Health Insurance bill is under way. According to the *Washington Post*, Madison Square Garden has been reserved for an August 6 rally to kick off the campaign. Max Fine, Director of the Committee for National Health Insurance, said a budget of more than $5 million will be needed for the selling job. Most of that, he said, would come from the AFL-CIO unions.

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NHI RESOLUTIONS

At the AMA Annual Meeting in St. Louis, the House of Delegates referred to the Board of Trustees five National Health Insurance Resolutions. The House called on the Board to determine if a new or a substitute bill for the AMA-proposed Comprehensive Health Insurance Act of 1977 is necessary. If an AMA-sponsored bill is to be submitted to the 1978 AMA Interim Meeting, the House asked that it be circulated to delegates as early as possible.

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NHI NEWSLETTER

As the National Health Insurance debate was rekindled, AMA introduced a new publication — *National Health Insurance Newsletter*. Published for the first time in May and designed for medical leadership, the newsletter digests news and views on NHI legislation.

DISEASE PREVENTION

Senator Edward Kennedy has introduced a disease prevention and public health education bill. The legislation would provide state grants for programs aimed at the five leading causes of death and disability, grants to private and public entities for health promotional campaigns, and technical assistance to state and local health promotion efforts. It carries a price tag of $150 million the first year and $300 million annual afterward. AMA Trustee Lowell H. Steen, M.D., said the AMA is generally supportive of the legislation but has some concerns about some of its provisions.

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SABOTAGE

The Department of HEW has asked the Justice Department to delay granting the nation's hospitals an antitrust law exemption. The AMA calls it a move to sabotage the voluntary effort to control hospital costs being carried out by the American Hospital Association, the Federation of American Hospitals and the AMA. HEW told the Justice Department that the voluntary effort might discriminate against smaller community hospitals and Health Maintenance Organizations and might hold down wages of hospital workers.

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IMPAIRED PHYSICIANS

The Minnesota Medical Association is joining with the AMA in sponsoring the Third National Conference on the Impaired Physician. The conference will be conducted from September 29 to October 1 at the Sheraton-Ritz Hotel in Minneapolis. Information may be obtained by contacting the AMA Department of Mental Health, 535 N. Dearborn St., Chicago, Ill. 60610.

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AMA-ERF LOANS

The American Medical Association Education and Research Foundation arranged loans totaling more than $7.3 million last year to medical students and physicians-in-training. There were more than 5,000 individual loans averaging $1,422 each. Since the program began in 1962, AMA-ERF has arranged and guaranteed loans amounting to about $85 million.

The Editor

Our new Medical Necessity Program has two worthy goals:

(1) To help contain costs.
(2) To upgrade medical care.

This program initially identifies 28 surgical and diagnostic procedures which will not be paid routinely by Blue Shield. All pertinent claims will be reviewed for medical necessity and covered only when a clear need can be proven.

Following is a list identifying the 28 surgical and diagnostic procedures:

1. Ligation of Internal Mammary Arteries, Unilateral or Bilateral
2. Radical Hemorrhoidectomy, Whitehead Type
3. Omentopexy — Portal Obstruction
4. Kidney Decapsulation, Unilateral and Bilateral
5. Perirenal Insufflation
6. Nephropexy
7. Circumcision, Female
8. Hysterotomy
9. Supracervical Hysterectomy
10. Uterine Suspension
11. Uterine Suspension with Presacral Sympathectomy
12. Hypogastric or Presacral Neurectomy
13. Fascia Lata by Stripper — when used to treat lower back pain
14. Fascia Lata by Incision — when used to treat lower back pain
15. Ligation of Femoral Vein, Unilateral and Bilateral — when used to treat Post Phlebitic Syndrome
16. Excision of Carotid Body Tumor — when used to treat Asthma
17. Sympathectomy, Thoracolumbar, Unilateral or Bilateral — when used to treat Hypertension
18. Sympathectomy, Lumbar — when used to treat Hypertension
19. Basal Metabolic Rate — BMR
20. Protein Bound Iodine — PBI
21. Icterus Index
22. Ballistocardiogram — BCG
23. Phonocardiogram with Interpretation and Report
24. Angiocardiography, using Carbon Dioxide, Supervision and Interpretation Only
25. Angiocardiography, Single Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
26. Angiocardiography, Multi-Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
27. Angiography — Coronary, Unilateral, Selective Injection, Supervision and Interpretation Only, Single View unless in an Emergency
28. Angiography Extremity

This program was developed in cooperation with The American College of Physicians, The American College of Surgeons and The American College of Radiology. We ask your support in making our Medical Necessity Program 100% effective.*

*A claims review by The Florida Plan indicated that most of the procedures were already being screened for medical need and few of the services in question were being performed in Florida.



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LEGISLATIVE NEWS

The 1978 Session of the Florida Legislature sputtered off to an erratic and slow start, but ended the last two days of the regular session and the special session in the usual hectic fashion. During the final hours, major bills passed with little debate and amendments tacked on at the last minute substantially changed many proposals.

A bill mandating Pap smears and breast exams for all female hospital patients (CSSB 169), that had previously been referred back to committee, passed with amendments setting up a statewide cancer registry and a requirement for hospitals to furnish patients or their representatives copies of hospital records. Legislation setting up a pilot project for chronic diseases (SB 552), was loaded down with amendments establishing a recruitment program for medical services in rural areas and provision for three county health departments to carry out a two-year demonstration project using the prepaid service approach for Medicaid recipients.

In terms of issues defeated, it was a successful year. Included in the list of bills killed were abolishment of mediation panels, state takeover of county health departments, certificate of need for physicians' office equipment, a state commission to regulate hospital rates, revisions to the Nurse Practice Act, and patient access to doctors' office records.

Two bills of significant interest to physicians that passed were the certification of radiologic technologists (SB 992), and revisions to the Worker's Compensation Law (SB 3-D). Detailed summaries of both bills will be included in a "Briefs" to all FMA members. The legislation on radiologic technologists requires physicians' office assistants using x-ray equipment must pass an examination demonstrating knowledge in safely operating x-ray equipment. A home study course will be developed by the Department of HRS and exams will be given two times per year in each HRS District. The Worker's Compensation revisions include increased authority to deal with fraud and changes in benefits for disability ratings. Each county medical society has been sent copies of these and the other bills of major interest. Copies will be furnished individual physicians upon request.

The 1979 Legislature promises to be an extremely active one. The complexion of the Senate will not likely be changed substantially as a result of the 1978 elections, but there are certain to be major changes in the committee structure and membership. A major shift is anticipated in the House with up to a 50% change in membership as a result of retirements and election results. Speaker-Designate Hyatt Brown has given early indication of a major revamping in committee membership and staff. These changes indicate the need for active key contact and county medical society involvement in educating members of the Legislature during the next few months. FMA field representatives and staff of the Capital Office will accelerate county medical society contact activities in order to assist in this critical task.

Submitted by the Council on Legislation and Regulations.

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Lord Northcliffe



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NORTH FLORIDA REGIONAL HOSPITAL
and
THE NORTH FLORIDA REGIONAL MEDICAL FOUNDATION
announce
THE FIFTH ANNUAL CARDIOVASCULAR SYMPOSIUM
September 14-15, 1978

The HILTON INN — Gainesville, Florida

Director: Howard W. Ramsey, M.D.
Co-Directors: Luis J. Cintado, M.D.
Thomas D. Bartley, M.D.

This fifth annual symposium is devoted primarily to a review and reappraisal of past and current concepts of diagnosis and treatment of coronary artery disease. A full and exhaustive review of recent data comparing medical and surgical therapy of patients with angina will be presented. Other topics to be discussed include bacterial endocarditis, the myocardiopathies and the current status of cardiac transplants.

A special section of the program, to be presented by Mr. Melvin Belli, will be devoted to an analysis and discussion of current medical-legal problems including the proliferation of malpractice suits.

An outstanding faculty has been assembled for the symposium and the program should be of interest to all physicians involved in the care of patients with cardiovascular problems.

FACULTY

Ralph Alley, M.D.
Christiaan Barnard, M.D.
Melvin Belli, Lawyer
Donald Effler, M.D.
Peter Gazes, M.D.
Goffredo Gensini, M.D.
J. Willis Hurst, M.D.
W. Dudley Johnson, M.D.
Arthur Mauceri, M.D.
Richard O. Russell Jr., M.D.
Earl K. Shirey, M.D.
Douglas R. Shanklin, M.D.
W. Jape Taylor, M.D.

As an organization accredited for continuing medical education, the Medical Education Committee of the Florida Medical Foundation certifies that this continuing medical education activity meets the criteria for 14 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. The medico-legal portion of the program is acceptable for 3 credit hours in Category 2. Approval for 18 hours Prescribed CE credit has been requested from the Florida Academy of Family Physicians, the Florida Board of Pharmacy and the American Society of Radiologic Technologists.

HOTEL RESERVATIONS: A block of rooms has been reserved at the Hilton Inn for symposium participants and reservations can be made through your local Hilton Inn, the Hilton Reservation Service (toll free number listed in your local telephone directory) or by calling the Gainesville Hilton Inn directly (904) 377-4000.

RESERVATION FEES: $175. - all physicians
50. - paramedical personnel (nurses, technicians, etc.)

MAKE CHECKS PAYABLE TO: FIFTH ANNUAL CARDIOVASCULAR SYMPOSIUM

MAIL TO: Howard W. Ramsey, M.D.
Program Director
North Florida Regional Hospital
P.O. Box 13494
Gainesville, Florida

For further information, call: Dr. Howard Ramsey or Hazel Sessions (A.C. 904) 377-8511, extension 195.

THE FLORIDA MEDICAL ASSOCIATION INC
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Historical Issue

William M. Straight, M.D.
Guest Editor

In this issue is presented —

An indepth study of Army medical care in Florida during the Seminole Indian Wars (1818 - 1856). A sketch of the life and times of Thomas P. Gary, M.D., 17th and 18th Presidents of the Florida Medical Association. This article, written by a recent graduate of the University of Florida College of Medicine, Bradford T. Williams, is largely based on a notebook left by Dr. Gary. And finally, a biographical sketch of surgeon Joseph Otto of Key West written with affection by his granddaughter, Mizpah Otto de Boe. Dr. Otto came to Florida as a hospital steward in the U.S. Army in 1849 and subsequently settled in Key West to live out the remainder of his life.—William M. Straight, M.D., Historical Editor.

Calomel, Quinine and Laudanum
Army Medicine in the Seminole Wars

William M. Straight, M.D.

"I am now writing without candle, with pine knots as a substitute, in a cabbage-tree hammock, in the centre of a large prairie, on a very dirty sheet of paper, which is the only one in camp."[1] As Colonel Zachary Taylor penned that postscript to his first report of the battle of Okeechobee at eight P.M. December 26, 1837, Surgeon R. S. Satterlee with the help of Assistant Surgeons A. N. McLaren and Josiah Simpson and Doctors Hannah and Cooke of the Missouri Volunteers were dressing the 112 wounded and packing up for the 150 mile trek through swamps, hammocks and pinelands to the Fort Brooke General Hospital at Tampa Bay.

Wounded of the Battle of Okeechobee

There was Edward Willis of the 4th Infantry who received a ball through the right arm fracturing the humerus just above the condyles.[2] The evening before he had been brought from the sawgrass swamp, seated on the ground near a similar lightwood fire, his clothing cut away and his arm washed. After he was given 30 or 40 drops of laudanum a tourniquet was applied near the



Surgeon General Thomas Lawson 1789-1861
(Courtesy of the National Library of Medicine, Bethesda, Maryland)

right shoulder and two assistants held the arm in a semiextended position. Surgeon Satterlee kneeling with his right knee on the ground rapidly incised the skin around the midportion of the upper arm with the razor-sharp amputating knife from his field surgical set. The assistant holding the upper part of the arm pulled the skin upward as Satterlee severed the little bridles of fiberous tissue which prevented its retraction. The skin having been retracted about two inches, Satterlee cut boldly through the muscles down to the bone at the edge of the retracted skin. The assistant then retracted the muscles, Satterlee removed the periosteum, then applying his left thumb to the bone as a guide for the saw, he sawed through the humerus without hesitation. Next he "took up the vessels" ligating them one by one after which the assistant released the tourniquet. Satisfied that major bleeding would not occur, Satterlee brought the wound edges together with adhesive straps leaving an anterior and posterior angle. From the latter a dossil of lint was allowed to project to provide drainage "for the pus that flows" in the event that union by first intention did not occur.[3] One of the assistants dressed the wound while Satterlee proceeded to the next patient.

There was John Spear of the 6th Infantry who had received a ball at the second rib anteriorly which came out just below the scapula. He was having difficulty breathing, had a cough and was spitting blood. Little could be done but dress the wounds of entrance and exit. There was Abraham Shaw of the 6th Infantry who had been shot in the left thigh; the ball had shattered the femur. Again the wounds could only be dressed and the leg splinted for, although amputation was desirable, in Satterlee's judgment he would not have survived the surgery. John Falvir of the 4th Infantry had received a ball which passed "through the parietes of the right hypocondriac region," and John H. Stanley, 6th Infantry, was shot near the anterior spine of the ilium, the ball "passing upwards under the parietes of the abdomen, and coming out at the upper part of the umbilical region." These also were wounds which could only be dressed.[2]

These men were part of a force of the regular U.S. Army and the Missouri Volunteers numbering about 800 who engaged a force of 380 to 480 Seminole and Mikasuki warriors on Christmas 1837. The Indians were firmly entrenched in a dense hammock which was surrounded on three sides by a sawgrass morass three-quarters of a mile wide and on the fourth side by Lake Okeechobee. The only route of attack was across the morass where the soldiers, up to their waists in water and mud, were easy targets for the Indian marksmen. By gallantry and determination the soldiers drove the Indians out of the hammock and scattered them in little bands down the shore of the lake and into the vastness of the Everglades. The cost to the army was fierce: 26 killed (including some of the best officers) and 112 wounded. The Indians later claimed a loss of 12 killed and 14 wounded.[4,5]

The firing began about half past noon and ended shortly after three in the afternoon. Then began the task of collecting the wounded from the swamp and hammock. A small footway was constructed over the swamp and one by one the wounded were carried to the dry ground of the prairie. Here the wounds were dressed and emergency surgery carried out while plans were made for the journey to Fort Brooke. Although Surgeon Satterlee later stated the army ambulances were "very serviceable," the more severely wounded could not withstand the jolting of the army wagons on the rough trail through the forest. Therefore Colonel Taylor ordered made,

> " . . . rude litters constructed with the axe and knife alone, with poles and dry hides, the latter being found in great abundance at the encampment of the hostiles. The litters were conveyed on the backs of our weak and tottering horses, aided by the residue of the command, with more ease and comfort to the sufferers than I could have supposed, and with as much as they could have been in ambulances of the most approved and modern construction."[6,7]

The army with their wounded left the battlefield (one mile southeast of the mouth of Taylor Creek along highways 98 and 441) on the morning of December 27th, and arrived at Fort Bassinger (Highlands County)[8] at noon of the 28th. After an overnight rest they were again on the road arriving at Fort Gardner (Polk County near Rosalie Post Office) on the 31st. On New Years 1838, the sick and wounded were sent on to Fort Brooke finally arriving there on January 4th. Here the seriously wounded and ill were admitted to the general hospital and, "the proper appliances and treatment were directed, the men subjected to the most rigid and abstemious diet (½ rations of bread) with simple and light dressings." Surgeon R. C. Wood later noted that of the 59 "most interesting and important" cases admitted to the hospital only one died, Abraham Shaw. Wood's report of the cases shows they were not trivial wounds: arm wounds, 25 with 6 fractures; leg wounds: 11 with 2 fractures; thorax wounds: 10; head, face and neck wounds: 7; skin wounds only: 6; hand wounds: 4; and penetrating abdominal wounds: 3 — none of which died.[2]

The Seminole Wars

A detailed account of the Seminole Wars is not appropriate but a brief account is helpful to provide a frame of reference. Those who desire more details should consult the recent and well-written "History of the Second Seminole War" by Professor John K. Mahon.

The Seminoles, so dubbed by the British in the late

18th century, probably first came to Florida at the invitation of the Spanish in the early 18th century. The first of these were Lower Creeks from along the Oconee River in Georgia, who settled in the panhandle west of the Aucilla River. These became known as the Mikasuki band and were the most militant of the Seminoles. About 1767, Upper Creeks moved into Hernando County and a final large immigration of some 1,000 Red Stick Creek warriors and their families came in 1814. Thus in the first quarter of the 19th century it is estimated there were about 5,000 Seminoles living in Florida. At first land and food were abundant and for several years relative peace prevailed. However, spurred by at least three factors: two British traders who aroused the Indians against the whites to further their personal interests, the sheltering of runaway slaves by the Indians, and the white man's unquenchable thirst for arable land, increasingly frequent and severe Indian-white clashes occurred. Finally, in early 1818, Major General Andrew Jackson invaded Spanish territory to "bring the Seminoles under control." This engagement which lasted several months has become known as the First Seminole War.

During the next 17 years Florida became a territory of the United States and repeated treaties were signed and attempts were made to get the Seminoles to peaceably remove to a reservation west of the Mississippi, but only a few bands went. Although the British agitators were summarily hung after a drumhead trial, the runaway slave problem and the white man's greed for land continued. Clashes between Indians and whites again increased in tempo with each side claiming deceit, treachery and cruelty. In this flammable atmosphere Major Francis L. Dade was ordered to march through the heart of Indian territory with a company of 105 officers and men as a show of strength. On the morning of December 28th, 1835, they marched into a well-laid trap and were massacred. This touched off the Second Seminole War, the longest and most costly, and the source of most of the material recounted in this paper.

The Second Seminole War did not end in a decisive victory and formal treaty. Rather small bands of Seminoles retreated into the vast Everglades and Big Cypress Swamp where it was impractical to hunt them down. Thus the war ended with Order No. 28 from the headquarters of the Ninth Military Department at Cedar Key that hostilities with the Indians cease on August 14, 1843.[9]

The Third Seminole War began on the morning of December 20, 1855, when "without warning" some 35 Indians attacked a survey party on the edge of the Everglades. The outposts of the Second Seminole War at Fort Myers, the edges of the Big Cypress Swamp, Cape Sable, Fort Dallas and Fort Lauderdale were reactivated. The Indians were pursued to their watery hideaways and their militant leader, Billy Bowlegs,



The Horse Litter

captured. He and 123 of his followers were sent west, but again a small remnant eluded their pursuers and it is their descendents we see in South Florida today.



Coacoochee, (Wild Cat.)

Coacoochee (Wild Cat), a Seminole War leader.

Medical Officers

The medical officers who served during these wars belonged to three classifications: regular armed services, volunteers and militia, and contract surgeons. Most numerous were the assistant surgeons and surgeons of the army. About 100 medical officers of the regular army were on Florida duty during the Second Seminole War.[10] Medical officers with volunteer or militia units are frequently spoken of as "Doctor" rather than "Surgeon" and their number is unknown. Finally, there were the contract surgeons, private practitioners who agreed to serve the troops at a given place for a limited period of time.

The requirements for a commission in the regular army medical department at this time stipulated that no one could be commissioned "who has not obtained a diploma or certificate from some respectable medical school, college, or society or passed the examination of the army medical board."[11] Usually the successful passing of the examination led to appointment as assistant surgeon. After five years of satisfactory service and the successful passing of a second examination, the medical officer could be appointed surgeon, if a vacancy for such was available. These examinations were more than mere formalities and some complained that they were unnecessarily difficult. Of 22 candidates for examination when the medical board met at New York in the winter of 1840, "five only were found to possess all the qualifications essential to an appointment," Surgeon General Thomas Lawson reported.

Sensitive to his critics, he countered that the quota of medical officers could still be met despite the high standards and he deplored the system of medical education that permitted " . . . the innumerable medical schools in every town, village and cross-road place."

Despite their superior professional attainments at least some of the line officers did not look favorably upon the medical officers. Thus Captain Nathaniel Wyche Hunter wrote in his journal about the army medical officers (1841):

> "What heartless, unsympathizing, Cold-blooded Creatures these doctors are! . . . This insensibility to the suffering of their patients they view as a positive virtue, . . . and Contend that the Same Destiny that marked them for the profession, Relieved them of that monkish Quality which would mar the practice of it." He goes on to say: "There are too many quacks in the medical corps of the Army who are fond of prescribing nostrums, patent medicines 'Roots & yarbs' — who not being able or willing to keep pace with the advancement of Science look upon all improvements and innovations with horror; and had Rather kill a patient according to the good old Secundem Artem Method of their ancestors, than Cure him by the newfangled practice of the day."[12]

In the Second Seminole War army surgeons on occasion functioned as line officers. Thus Lieutenant Colonel Thomas Lawson, who a short while later became the medical director in Florida and ultimately the surgeon general of the United States, shared the command of the Louisiana Volunteers when they took the field in February 1836. Another such instance occurred on December 18, 1835, when Dr. McLemoure with 30 horsemen came upon about 80 Indians led by Micanopy ransacking an army baggage train (The battle of Black Point). The good doctor ordered a charge and

spurred his horse but his men did not follow. His horse shot out from under him, he proceeded on foot "with sword in hand," but he finally realized his men would not support him and beat a hasty retreat thus escaping wounds.[13] In 1840 a regulation appeared that forbade medical officers to serve in a command status in any situation.[14]

Service as a medical officer in Florida was described by Surgeon General Lawson as: " . . . not only irksome, but exceeding laborious and hazardous, many of them having from the very dispersed state of the troops, to give their attendance to two, three or more posts or stands; frequently passing from one station to another without an escort, and occasionally under the fire of the enemy."[15] Sprague notes that prior to 1848 ten army medical officers died during duty in Florida; nine of disease and one of wounds inflicted by the enemy.[16] The single battle casualty was Assistant Surgeon John Slater Gatlin who accompanied Major Dade on his ill-fated march.

The Uniform

On dress parade the regular army surgeon wore a dark blue coat with two rows of gilt buttons embossed with a spread eagle and stars. These extended in right lines, ten in each row, from the collar to the bottom of the lapels. The collar was a black velvet standing collar, fastened in front with hooks and eyes, and embroidered at each anterior end with a gold laurel branch five inches long and a gold vine of laurel leaves along the outer edges. The shoulders were topped by gold epaulets with a solid bright crescent on which was embroidered a laurel wreath surrounding the letters "M.S." in old English characters. From the crescent hung bullion which varied in size and length according to rank. The coat cuffs were of black velvet, three inches deep with embroidery similar to that on the collar. He wore a black cocked hat, trousers of dark blue cloth with a black stripe down the outer seam in the winter and white linen or cotton trousers in the summer, and black boots with gilt spurs. His belt was black patent leather with a gilt "plate" having the letters "M.S." and a small sprig of laurel in silver upon it. From this belt hung a small sword and scabbard. White gloves completed the formal dress.

For "undress" the surgeon wore a single-breasted frock coat of dark blue cloth with stand up collar, regulation buttons in a single row, pockets in the skirts and a silver lace shoulder strap according to grade. During battle with a "civilized" foe the medical officer wore a green sash to indicate his noncombatant status.[17] In the field in Florida, officers and men, "dressed like privates from General Clinch downwards. A small lace shoulder strap was the only distinction."[18] This was to thwart the Seminole tactic of killing the officers first. Bemrose, a hospital steward during the Second Seminole War, tells us that his superior, Assistant Surgeon Richard J. Weightman, customarily wore a black dress coat at the post.



Surgeon Richard Sherwood Satterlee 1798-1880 (Courtesy of the National Library of Medicine, Bethesda, Maryland)

A Surgeon's Pay

The medical officer's pay was the equivalent to that of the line officer of the same rank. The assistant surgeon was equivalent to a first lieutenant, if he had less than five years of service, or a captain, if five or more years of service. A surgeon had the rank of a major. One disgruntled army surgeon in 1836 grumbled that he received "only $30 per month pay, and $24 for subsistance . . . Respectable board, lodging and washing cannot be obtained at any southern station, which are the only ones with which I am acquainted, for less than $28 or $30 per month: leaving $24 for clothing, incidental expenses, and the laying up for a wet day."[19] Contract surgeons were paid according to the number of men at the post: 100 or more men, $40 per month; 50 to 100 men, $30 per month; and less than 50 men, $20 per month. If the surgeon furnished the medicine he was entitled to another 25 to 50%.[20] If a regular army assistant surgeon of more than five years service was killed in battle, his widow received $25 a

month for five years.[21] If on the other hand he died of a disease contracted while on active duty, his widow received nothing. If the surgeon belonged to the militia or a volunteer regiment, the widow was entitled to half pay whether he died of battle wounds or disease.[22]

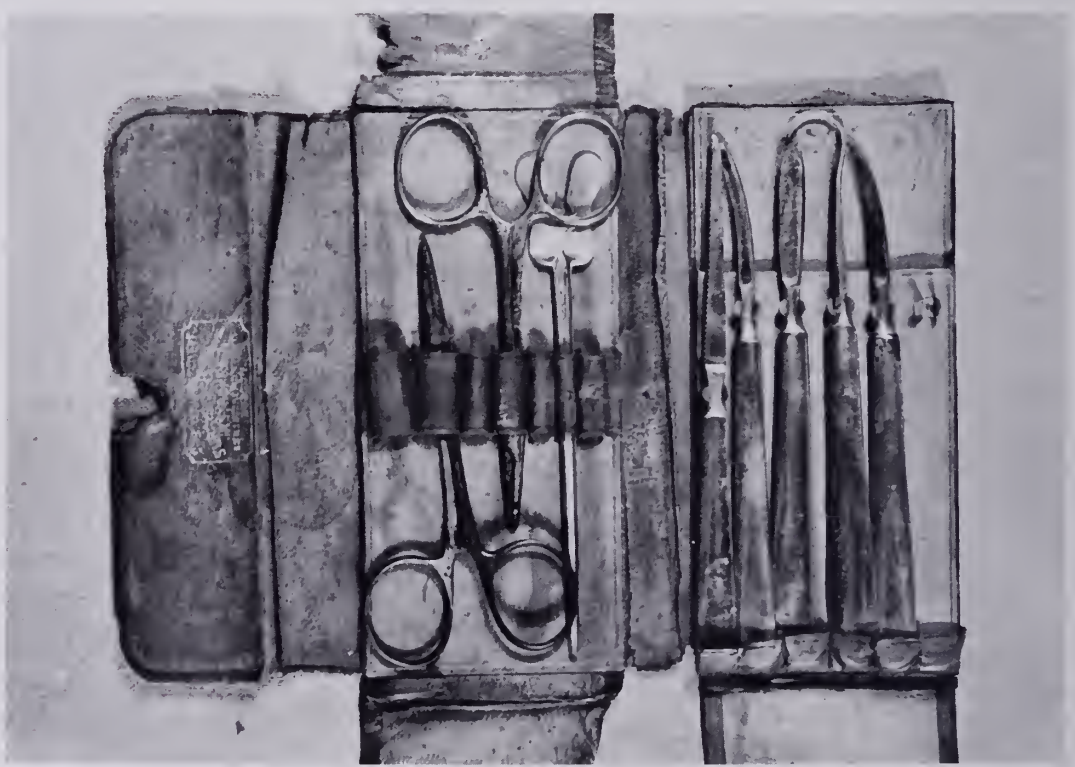
The Hospitals

Each of the semipermanent and permanent forts of the Seminole Wars had its hospital. These varied from a tent with a dirt floor to a masonry building. Sometimes the hospital occupied rooms in a building used for other purposes. Captain Hunter commented upon the hospital rooms above the commissary store at Fort Nelson:

> "The Hospital is (with a providence I know not how to appreciate) placed immediately above the Commissary Store — The doom of Tantalus was slight compared to that of the poor victims of disease and dietary course who languish on the floor above. How fragrant the Scent of putrid pork and grateful the odours of spoiled beans to those whose daily dose has been a pill or potion? The inhalations of such nauseous exhalations may possess a Sanatary influence upon the principle that poisons counteract each others effects — I don't know — I'll ask the Dr. tomorrow — but I do know that if ever I'm ordered to construct a hospital and sufficient means afforded I'll not put it over a commissary store."[23]

The hospital of a more permanently occupied station is illustrated by the facility at Fort Dallas on the north bank of the Miami River near its mouth. The hospital at Fort Dallas is described in June 1856 as two wards 15′ x 19′, a mess room 20′ x 13′ and a kitchen 10′ x 12′. Across the front of the building was a "piazza" eight feet wide.[24] The building was probably of dressed-log construction and the roof was thatched with palmetto fronds which had to be carried a half a mile through a hammock to a boat and then four miles by water to Fort Dallas.

General hospitals were located at St. Augustine, St. Johns Bluff (Mayport), Picolata, Cedar Keys (Atsena Otie Key) and at Fort Brooke (Tampa). The hospital at Fort Brooke sat in a grove of live oak trees on a sand bluff overlooking the Hillsborough River. A description of 1835 states: "The building is of frame and log-work, one hundred and sixteen feet long by twenty feet wide and is surrounded by a gallery ten feet wide — all in a very good state of preservation. It is divided into four rooms and two passages. Two of these are appropriated for the use of the sick, a third as a Dispensary, and the fourth for a kitchen."[25] The description further speaks of Ward No. 1 as 23 feet long by 18 feet broad and 11 feet high. It had one door and six windows and conveniently accommodated 12 men in four single bunks and four two-tiered ones. The surgeon making the report suggests that if all bunks were two-tiered, 32 patients could be accommodated in the hospital. By certain alterations of the hospital's internal arrangement, the building of a separate kitchen and the two-tiered bunks, he felt the hospital could be made to accommodate any number of patients likely to be sent there. General hospitals were the collecting point for the more difficult



Surgeon's Pocket Case

or prolonged cases and for the overflow from post hospitals in their area.

A glimpse of a regimental hospital pharmacy is provided in the reminiscences of a soldier who was drafted to become a hospital steward:

> ". . . and so I was forced to become a doctor against my will. Well, after all it was not much, for the whole stock in trade of the pharmacy of a regimental hospital, in those days, was Peruvian bark in a powdered state. Its more powerful extract, quinine, calomel, laudanum, was a great stand-by in those days. Bitter aloes was much used, seidlitz powders, ipecac, jalap and, perhaps, the number of drugs could be counted on one's fingers and did not take very long to learn their names, medical properties and quantities to be used, and the variety of diseases among soldiers was not so great. So I became quite a doctor in a little while. Bleeding and cupping were practiced a great deal, and I became so proficient in these that I was frequently called by the town people outside; and I made a good deal of extra money by my outside practice."[26]

There were times when an epidemic turned an entire picket fort into a hospital. A vivid description of an epidemic at Fort Drane (Marion County) in April 1836 is given by the hospital steward, John Bemrose:

> "We had a great accession of patients, the hospitals were much thronged and deaths often occurred. The poor fellows who lay in the shed abutting the picket fence were in a deplorable condition; only imagine a long shed, 150 yards in length, a mere temporary affair covered only with bark, and letting in at the cracks both sun and rain! In this poor shelter the poor men lay exposed to the miasma of the morass and with no comforts, but daily breeding diseases of the malignant type! You will say, why not get them placed more comfortably. I answer that it was impossible at that period, the fort not being large enough. We had seven large buildings and the hospital tent filled with desperate cases, and the sheds were all that could be arranged until the fort could be enlarged. When I went along those sheds of a morning to administer to each man his remedy, I really felt disgraced and humbled to see fine athletic fellows in the lowest state of misery and thoroughly cast down by the magnitude of their discomforts. One would exclaim, 'Steward, for mercy's sake get me out of this!' Another would groan deplorably, saying, 'I shall be steamed before the day is over.' Sand flies and mosquitoes were innumerable, all adding to their troubles. Centipedes, cockroaches, scorpions, with immense spiders, were daily tenents of the place, and at night we were surrounded by myriads of wolves who kept up a continual yelling. This, with the croaking of immense bullfrogs, was not conducive to rest. The sand of the fort was full of chigoes (chiggers), and a sort of black flea. This latter was the greatest (pest) to all of us."[27]

Instruments and Diagnostic Methods

In the days of the Seminole Wars diagnosis was entirely a matter of the history, physical findings and the course of the disease except in rare instances. It is likely that percussion of the chest was practiced at times when consolidation of the lung or fluid in the chest was suspected. This technique had been introduced in Vienna by Leopold Auenbrugger in 1761 and had been popularized by Jean-Nicholas Corvisart in the early 19th century. Although the stethoscope was introduced in France in 1819 by Rene-Theophile-Hyacinthe Lannaec and found its way to Quincy, Florida by 1846,[28] its use is not mentioned by army surgeons in their reports and the instrument does not appear on the supply table. Meterological thermometers were available at most of the army posts in Florida and the surgeons were expected to keep accurate records of the ambient temperatures, but there is no mention of the use of the clinical thermometer and this instrument does not appear on the supply table. The pulse rate and the feel of the skin seem to have been the surgeon's guides to fever. The consistency and color of body discharges: urine, stool, vomitus and wound drainage, are frequently noted and used in diagnosis.

In "Letters From the Frontiers," Major General George A. McCall implies the presence of a microscope at the United States Naval Hospital in Pensacola in February 1823, but it seems to have been used for the study of pathological anatomy rather than clinical laboratory examinations.[29] A number of gross autopsies were performed by the army surgeons during these wars, both at small post hospitals and at the general hospitals. The reports of these, sometimes in great detail, are to be found in the Monthly and Quarterly Reports of the Sick and Wounded at the National Archives in Washington. In a review of some 1800 of these reports 21 autopsies were noted and it is likely some were missed and possibly autopsies were done and not reported.

Disease Killed More Than Bullets

In the Florida wars, as in all wars, disease killed many more soldiers than did enemy action. It had long been recognized in the South that the summer months brought the fevers. From the early settlement of the South, people of means had annually left their plantations and journeyed to the mountains of Tennessee and North Carolina, and to such spas as Saratoga Springs and Niagara, N.Y. to escape the fevers. Thus during the first years of the Second Seminole War all active campaigning ceased during the summer months and the troops were removed from the field leaving small garrisons at the most strategic outposts. The Indians relieved of the pressure of pursuit used these months to plant and harvest crops, prepare and store food for the coming winter, replenish their arms and

ammunition and hold councils to plan the next winter's strategy. As this became evident the army leaders made the decision to press the active campaign summer and winter despite the hardships of heat and insects, and the risk of disease. Some thought this a foolhardy decision but it was implemented beginning with the summer of 1841 and proved to be popular with the troops as well as successful in prosecuting the war.

The Fevers

In Seminole War times fevers and dysentery were the most numerous and the most fatal diseases. Fevers were classified as intermittent (febrile spikes separated by completely afebrile periods), remittent (febrile spikes separated by intervals of lower but not completely normal temperatures) and continuous (sustained fever with little fluctuation). The intermittents were further divided according to the length of the fever-free intervals: quotidian (a daily fever spike but much of the 24 hours afebrile), tertian (two fever spikes in three days with one full afebrile day between), and quartan (two fever spikes in four days with two afebrile days between).

The intermittent fevers, which we today recognize as forms of malaria, were by far the most numerous of the fevers but infrequently ended fatally. The term "malaria" was in general use at that time but described a geographical area or a condition of the atmosphere that gave rise to fevers rather than a specific type of fever. The remittent fever, sometimes designated as bilious, malignant or putrid remittent fever, we designate today as yellow fever. The term "yellow fever" was occasionally used at this time but this disease is most commonly referred to as the bilious remittent fever or febris typhus icterodes. Outbreaks of yellow fever, often with many deaths, occurred somewhere in Florida in 27 of the 38 years constituting the Seminole War period.[30] It was thought by many that if intermittent fevers were allowed to go unchecked they would "run into" remittent fevers.

Typhoid fever, also called the ardent fever, was the name applied to an inflammatory diathesis without signs of local inflammation. Typhus was used for a fever associated with a punctate rash, probably murine typhus as we know it today, and was also known as nervous fever and camp fever. The term "congestive fever" which is commonly used signified fever with associated presumed congestion of the internal organs and was used to describe any severe case of fever of whatever type. There were other specific febrile diseases designated according to the clinical picture: dengue, hepatitis, measles, influenza, smallpox, scarlet fever and puerperal fever to name a few. Of course there were many causes of fever unrecognized at that time such as endocarditis, rheumatic fever, mononucleosis, leukemia, malignant tumors and collagen diseases.

The clinical picture that the doctor saw in the instance of the bilious remittent fever is graphically described by Assistant Surgeon J. P. C. McMahon in the fall of 1821 at St. Augustine:

> "The premonitory symptoms were few and variable. Pains in the head, back and loins generally preceeded or accompanied by a chill announced the onset of the disease. . . . The reaction from the general or partial chill which ushered in the disease presented in most cases, a flush on the face, neck and breast, with a throbbing in the temporal or carotid arteries; an increased pain of the head; watery suffused eye; great heat on the surface of the body while the extremities remained cold; shortened respirations attended sometimes with sighing and deep Inspirations, an irritable stomach ejecting first its injesta and then a fluid deeply tinged with yellow bile, the pulse at the wrist . . . always indicating a high degree of inflammatory action in the arteries while the patient frequently complained of great prostration of strength. The tongue, . . . was slightly overcast particularly about its centre, with a light buff, or pale yellow hue, and almost invariably swollen. The urine high colored, frequently discharged, but in small quantities . . . To the preceeding symptoms, particularly after their continuance for a short time may be added oppression about the pracordia, a sensation of great heat and burning in the stomach, a soreness or a fatigued feeling in the muscles of the extremities, with anxiety and restlessness. Those symptoms would remit and recur with aggravated or diminished force, according to the violence of the disease or the efficacy of the remedies used . . . To these symptoms which may be considered as constituting the first stage of the disease and which did not continue longer than the first or second day succeeded an entire remission of the febrile and other unfafourable symptoms; . . . the patient often fancied himself well — But this transitory delusion was of short duration — A more melancholy train of symptoms was soon to succeed — It was now that the mind became the sport and wreck of an unconquerable delirium; sleep was exchanged for perpetual watchfulness . . . the eyes became yellow, a yellowness also appeared, first, about the angles of the lower Jaw, and on the neck and spread gradually over the body. Petechia never appeared but the skin was moistened with a cold clammy sweat; the pulse small, feble and irregular and sometimes before death, absent for sometime, from the wrist; hiccough, suppression of urine without pain, hemorrhagy, from the nose, gums, bowels &c. A slight convulsive motion of the stomach announced the approach of the black vomit, the certain harbinger of death. Such was the usual course and progress of the disease, when it terminated fatally from the third to the fifth day. There were few if any cases within a shorter period; but many cases were protacted to the seventh or eighth day."[31]

The cause of fevers, whatever their clinical manifestations, was thought to be noxious exhalations from swamps and marshes and from jungle areas when the shrubs and trees had been removed. Repeatedly in the writings of the day it is noted: " It is a well known fact that military stations, near jungles, often continue healthy

until the soil is brought under cultivation, or the trees and shrubbery cut down exposing the boggy surface to the agency of solar action."[32] Surgeon Samuel Forry further notes: " . . . it is generally believed that the presence of dead animal matter, when mingled with vegetable remains in a state of decay, gives rise, . . . to miasms, . . . of a more deleterious character than those resulting from vegetable remains alone."[33] Certain of the epidemic diseases such as epidemic and exanthematic typhus and yellow fever were thought to spread by "a diffused and impalpable effluvium or vapour, emanating from the secretions, excretions, and surfaces of persons already affected."[34]

Whereas the clinical manifestations did not indicate a specific cause for a fever, they did govern the choice of therapy during the course of the disease to some degree. Although purgation with calomel and the exhibition of quinine was the most popular regimen, other measures were also used. Early in this period the lancet was freely employed if the surgeon perceived "an excess of arterial action." Bemrose commenting upon the practice of his post surgeon at Fort Drane (Marion County) March 1836 tells us: "Dr. Herskill (possibly Assistant Surgeon H. L. Heiskell) had a great liking for the lancet; he seemed to feel he got rid of his patients more readily. I have known him to mark out from our daily patients 15 or 20 with the V.S. to their names."[35] In the later years of the Seminole Wars venesection lost some of its popularity as a treatment for fevers.

Tincture of opium in doses of 30 or 40 drops hourly beginning four hours prior to the expected chill followed by quinine "for a day or two," according to Assistant Surgeon John C. Glen, "seldom failed to break the fever entirely." Emetics such as ipecac were commonly employed early in the course of the disease to produce "copious vomiting of bilious matter and vitiated mucous." Diuretics and diaphoretics such as potassium nitrate were given just before a chill to avert or mitigate the succeeding paroxysm of fever. A popular therapeutic combination of the day was: eight or ten grains of potassium nitrate, an eighth of a grain of tartar emetic and from a fourth to a half grain of calomel administered every two or three hours. This was thought to promote most of the secretions, particularly those of the liver and skin, and thus lessen the "febrile excitement." Calomel, second only to quinine, was the most commonly used drug and it was given in doses of 20 or 30 grains a day. At times it was apparently given in much larger doses and Assistant Surgeon Leonard C. McPhail reported three cases of "ptyalism" arriving from another post " . . . in a dangerous state threatening gangrene of the mouth and jaws."[36]

The sovereign remedy for all fevers, however, was quinine. At the beginning of this period quinine was only available as powdered Peruvian bark usually administered dissolved in wine. French chemists, Pelletier and Caventou, isolated quinine sulfate from the bark in 1820 and the first quinine factory in the world



Spring Lancet for Bloodletting

opened in Philadelphia in 1823. By the outbreak of the Second Seminole War quinine sulfate in purified form was usually available to the troops. Initially quinine was thought to be useful only in treatment of the intermittents and then only when the system had been properly prepared and when given during the afebrile period. Ten to 20 grains were given several hours before the next expected fever spike. However, this proved therapeutically inadequate in the Florida Territory and larger doses, sometimes administered during the febrile period, were resorted to. This practice has been hailed as the significant medical contribution of the Second Seminole War, but it appears the practice had been introduced before 1822 in France[37] and had been utilized by Dr. Henry Perrine and others as early as April 1826.

Assistant Surgeon Charles McCormick who wrote about this custom recommended it for both intermittents and remittents. He advised giving four to six grains of quinine every hour beginning four to six hours prior to the next expected paroxysm of fever. At times he gave as much as 300 grains in 24 hours. As might be expected, his patients uniformly had "ringing and buzzing in the ears, a sense of stricture across the forehead, and temporary deafness."[38] Some surgeons believed there were critical times in the course of the illness (the 7th, 14th, and 21st paroxysms) when the intermittents tended to remit spontaneously. On such days they thought quinine had increased effectiveness. Others rejected this concept. Some thought the use of quinine led to diseased livers and enlarged spleens or ague-cakes, as they were called, but a number of autopsies were done in the post and general hospitals in Florida and splenomegaly was infrequently found. Daniel Drake (1785-1852) rejected the concept that splenomegaly resulted from quinine therapy: "If this ever happened, it was because the lancet had not been adequately employed before resorting to that medicine (quinine) . . . the sooner the Fever is checked, the less is the danger of enlarged spleen."[39]

Daily doses of quinine were also advised to prevent malaria. One reference[40] gives the dose as three grains of quinine in a gill of whiskey to each soldier each day while in malarious regions. Assistant Surgeon Pascal A. Quinan at Fort Capron (St. Lucie County) in March 1856 notes that as little as one grain daily will prevent recurrence.[41]

Dysenteries and Diarrheas

Next to the fevers the diarrheas and dysenteries were the most common causes of morbidity and mortality. Post surgeon Jabez Heustis gives a graphic description of dysentery at Fort Gadsden (Liberty County) in 1818:

> "During the months of March April and May, Dysentery was the prevailing complaint. It generally commenced with some griping, and frequent evacuations, though not often attended with a discharge of blood — the stools being generally watery and copious. After the first 3 or 4 days the complaint generally assumes the character of diarrhoea or flux, often unattended with griping, but which by its inveteracy and the frequency of the evacuations rapidly exhausted the patient. The generality of the cases were unattended with fever. Sometimes the tongue was of a firey red colour. This was an unfavorable symptom, though not always a fatal prognostic. When fever existed together with the flux the prognosis was generally unfavorable, more especially if the fever Supervened in an exhausted state of the patient. During the months of April May and June there were 20 deaths at this Post, of whom 12 died with the flux. There were generally at this time as many as 150 on the Sick Report under the care of different Surgeons and mates. The causes of the bowel complaints in the form of Dysentery and diarrhea I conceive to have been, fatigue, exposure, coarse diet, and want of vegetables."[42]

The prevailing theory of the cause of diarrheas and dysenteries at that time is stated by Assistant Surgeon J. J. B. Wright as that of the French clinician, Francois-Joseph-Victor Broussias (1772 - 1838): "Long-continued atmospheric heat, combined with moisture, has an invariable tendency to induce chronic inflammation of the mucous coat of the larger bowels, thus giving origin to diarrhoea and dysentery, with ultimate ulceration of the colon and rectum."[43] Other surgeons thought at least one factor was the "turbid water from stagnant pools" the soldiers were forced to drink and Captain Nathaniel Hunter has this to say about the water at Fort Nelson:

> "I don't see how we can possibly live here for a month and drink such villainous water. Besides its warmth and discoloration by the infusion of noxious stuffs, it generates myriads of wiggle-tails and pollywogs which are anything but palatable in a state of animation. A slight infusion of 'Ole Rye' removes all deliteries gurgleitis and cooks the animalculae to perfection and renders the mixture quite agreeable."[44]

Occasionally a more tangible cause of dysentery was identified:

> ". . . the Dysentery which has prevail'd and still continues to prevail, epidemically — What is remarkable, **all** the cases happening at the Post have been complicated with worms, and presented the character of 'verminous fever' — with inflammation of the mucous structures of the larger intestines — large quantities of *Ascarides* in some cases, and in others numbers of *Lumbrici* were voided at stool — in two instances they crawled from the mouth."[45]

From the vantage point of 140 years later we can speculate that the febrile dysenteries may have been virus, shigella or salmonella in origin, and the afebrile ones due to staphylococcal or Clostridium perfringens food poisoning, toxigenic E. coli or possibly functional bowel disorders. It is possible that some of the afebrile diarrheas were manifestations of pellagra. The soldier's

ration provided at best only one third of the daily requirement of niacin. However, the other manifestations of pellagra are not described. Also worthy of consideration are the parasites Entamoeba histolytica and Giardia lamblia and perhaps rarely diseases such as ulcerative colitis and Crohn's disease.

Therapy was entirely empirical. Assistant Surgeon Richard M. McSherry in December 1839 reported he used: "Opium in large doses with a diet of the mildest kind . . . The Sulph. Morphiae in doses of Gr. ¼ administered in Infus. Lini and repeated pro re nota is generally successful when the case is not too advanced. In the meantime cups over the abdomen followed by warm poultices or fomentations have been freely used . . ."[46] Assistant Surgeon J. B. Wells recommended the use of " . . . Elliottson's pill of Copper & Opium aided by enemas of zinc and alum in cases of chronic dysentery." Still others advised lead acetate as an astringent and ipecacuanha as a diaphoretic in diarrheas. Several surgeons mention that if all else fails cure might be had by moving the patient to a cooler climate.

Vitamin Deficiency Diseases

Among the more frequently reported diseases of the army in Florida were the vitamin deficiency diseases, scurvy and nightblindness. Assistant Surgeon Robert Archer reported from Fort King (Marion County) in June 1835:

> "We have had nine cases of scurvey in the companies from Fort Marion (St. Augustine). The first occurred on the 18th April — 26 days after our arrival at this Post. The symptoms throughout were of a very aggravated nature, commencing with fever accompanied with much gastric derrangement, spongy condition of the Gums, acute pains in the loins and lower extremities resembling rheumatism. A close inspection of the legs will generally exhibit minute vibices (petechiae) resembling flea bites; hardness of the Gastrocnemii muscles and rigidity of the flexor tendons of the legs terminating in contractions. In a few days the affected leg assumes a yellowish hue, the vibices put on a more intense purple til the whole extremity becomes at last suffused with Ecchymosis."[47]

There are many similar reports from surgeons throughout the Florida Territory. Although deaths due to scurvy are reported, it appears the mortality was low.

The cause of scurvy was well recognized to be a deficient diet: " . . . but there is one condition which is necessary for its production, viz. prolonged abstinence from succulent vegetables or fruits, or their preserved juices as an article of food."[48] The soldier's ration as recorded by Potter[49] provided about three times the currently accepted daily requirement of protein, a negligible amount of vitamin A, one third the daily requirement of niacin, and two thirds the daily requirement of vitamin C, if 200 grams of potatoes were eaten daily.[50] Of course the allotted daily ration was often not fully available because of the great difficulties of transportation on the frontier. This was especially true for the outlying posts and troops in the field but applied from time to time to well established posts. Assistant Surgeon William H. Babcock gives us the picture at Fort McRee (Martin County) in 1857: "The only vegetables received at the post, during the five months it was occupied, were three barrels of potatoes (of which only a barrel and a half were edible) and a few cabbages."[51]

One might reasonably ask why in this land of sunshine, vegetables and citrus fruits were not always available. Around the more established posts in north Florida it is likely gardens were cultivated but often an interior post would be occupied too short a time to plant and harvest a crop. Troops on the march were dependent upon what they could carry and the occasional raiding of farms or the discovery of vegetables stored in hammocks by the Indians. Nature seems to have dealt the troops a wicked blow in this regard also, for a freeze occurred in the early part of 1835 destroying "all the groves in the northern part of the peninsula."[52] Thus it is likely the supply of citrus was severely reduced for it usually takes six or seven years for a newly planted grove to bear.

As the body uses up its supply of vitamin C in two to four weeks, scurvy frequently occurred when the troops took the field on extended forays. Thus Assistant Surgeon Thomas A. McParlin marching with five companies from Fort McRee on the eastern shore of Lake Okeechobee to New River and then down to Fort Dallas in 1857 reported: "A grove of wild oranges on the southwest side of the Miami (River) cured for me several incipient cases of scurvy . . ."[53] It seems likely he is referring to the sour oranges that used to be abundant in Brickell Hammock.

Treatment of scurvy was the supplying of fresh vegetables, lime juice, oranges and sliced raw potatoes in vinegar. When vegetables were not available at Fort Armstrong (Pasco County) Assistant Surgeon Samuel Forry used liberal quantities of wild pepper-grass (Lepidium virginicum) to treat scurvy with success.[54] From the pharmacopoeia quinine and nitrous preparations were used in addition to the diet.

Nightblindness which was sometimes spoken of as nyctalopia, hemeralopia (strictly speaking this means dayblindness) and paropsis noctifuga seems to have been frequent in Florida. Today we recognize nightblindness as the earliest symptom of vitamin A deficiency but in the Seminole War days it was thought due to " . . . an exhaustion of the power of the retina in consequence of exposure to strong light during the day . . ."[55] As we have seen, the soldier's ration provided negligible amounts of vitamin A and that coupled with the

dysentery which was so prevalent and which depleted the body's store of vitamin A, most likely brought about the nightblindness.

Therapy of nightblindness at that period is described by Forry: " . . . confinement to a dark room, use of emetics and cathartics, and the application of cups and blisters to the temples and nape of the neck."[55] If these measures failed, he suggested salivation or removal to "ones native clime." William Babcock further recommended "green shades before the eyes."[56]

Other Diseases

A spectacularly painful but nonfatal disease that appeared twice during these wars was the breakbone fever, also known as dengue, dandy fever and rheumatismus febrilis. This appeared in the Caribbean in the fall of 1827 and spread via the shipping routes to Pensacola in the summer of 1828. A second visitation occurred at Fort Brooke[57] and Jacksonville in the fall of 1850.[58] The accepted therapy was the lancet and cathartics early in the disease and diaphoretics and anodynes such as opium and Dover's powders for relief of pain.

Cholera, "the scourge of the human race," appeared at Apalachicola in June 1833 causing most of the inhabitants to flee.[59] At that same time the brig Ajax bound from New Orleans to Liberia with 150 emancipated slaves aboard put in at Key West with cholera aboard. This resulted in ten or 15 cases in the town with nine deaths.[60] Cholera returned to Apalachicola for a second visit in December 1851.

Smallpox appeared in St. Augustine in November 1842, at Tallahassee in November 1845 and in Jacksonville in the summer of 1852. The extent of these outbreaks seems to have been small and the army not affected, perhaps because smallpox vaccination had been routine for all army personnel since May 1812.

Typhoid fever appeared epidemically in north Florida in 1851[61] and smouldered for six to eight months with a small mortality but again the army was not involved. Scarlet fever appeared at Quincy in January 1845 and resulted in two deaths but it was limited to the civilian population.[62]

Gonorrhea and syphillis were not uncommon among the soldiers at various outposts in Florida. A medical officer in a camp near Pensacola commented: "The highly dissolute and licentious character of the citizenry and Soldiers gives promise of further unlimited extension of these filthy diseases."[63] Rheumatism and catarrah were commonly reported and "requiréd the free use of the lancet and other depleting remedies."[64]

Acute hepatitis with some fatalities was reported from various stations at different times. Influenza and measles swept north Florida in the winters of 1836 and 1837[65] and a third visitation of the influenza with two fatalities was reported from Fort Barrancas, Pensacola, in September 1843 by Assistant Surgeon Samuel Preston Moore who later became the Surgeon General of the Confederacy.

Emotional Illness

Psychiatric problems cropped up from time to time during the frontier war. Removal from the usual walks of life, loneliness, boredom and the chronic threat of an unexpected Indian attack were calculated to unseat the minds of the less well organized personalities. Bemrose records a case which seems to have been an acute schizophrenic reaction to a night attack of the Indians at Fort Drane. He tells us the soldier became " . . . completely an idiot. At intervals crying out, 'Don't you hear them, Indians, Indians, turn out, Indians . . ."[66] Assistant Surgeon Ellis Hughs in his diary records four suicides of which he had knowledge.[67]

Therapy for emotional disorders was quite primitive. Bemrose speaks of restraining his patient: "During the night I was obliged to have him bound to the floor, to keep him from damaging himself and others." He further tells us that treatment with cathartics, blisters and cataplasms (poultices) to bring the excitement to the surface was unavailing. Captain James Barr describes the treatment of a soldier who became insane at Fort Brooke in April 1836: " . . . he was chained by the leg, outside the Fort, with nothing whatever to shade him from the burning sun. He was kept in this state several days; he was at length admitted to the hospital, but it was too late; he died soon after . . . Such conduct in the medical department should not **be overlooked**."[68]

Whiskey — The Root of Much Evil

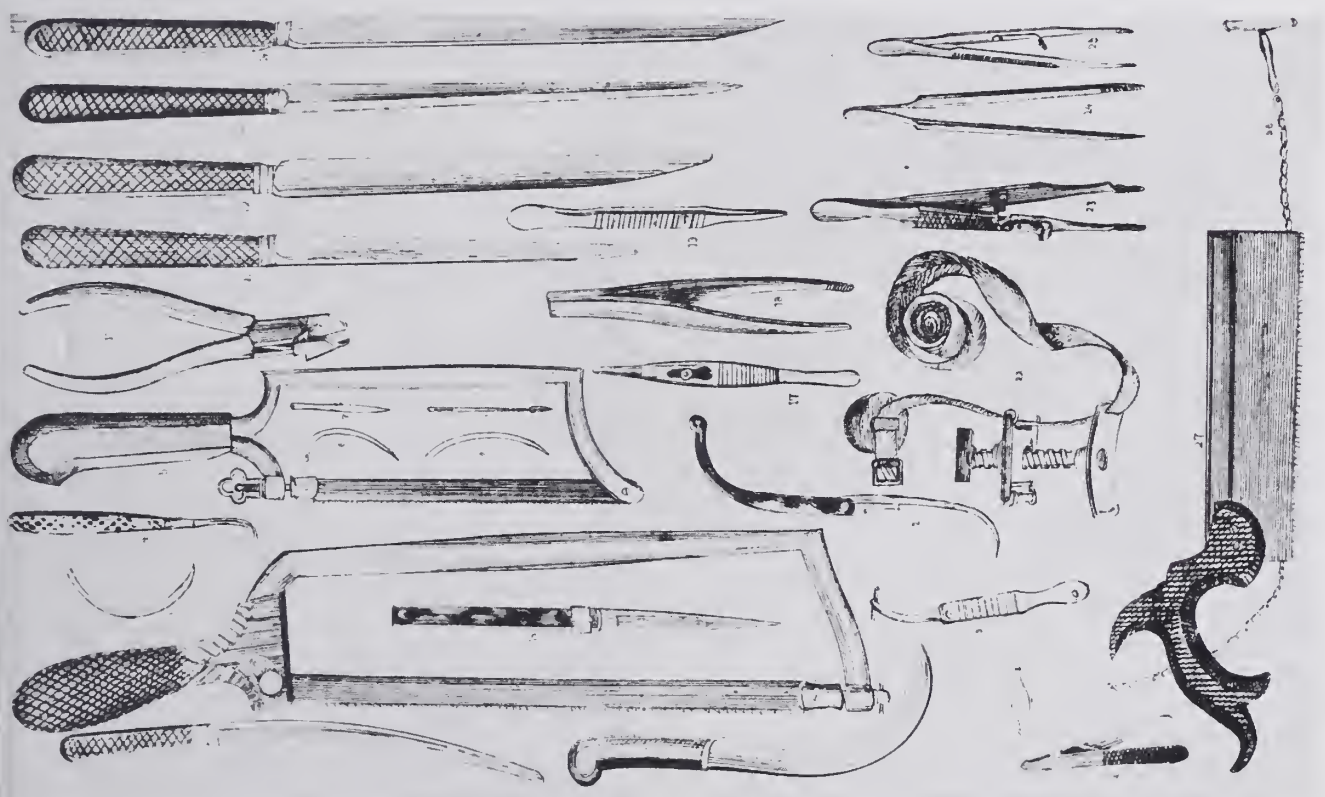
One of the most difficult problems of the armed services in this period was drunkeness. Stimulated by the long periods of isolation, boredom and inactivity and aided by the remarkable availability of rum and whiskey, drunkeness became unmanageable. A daily allowance of a half pint of rum or whiskey was a standard part of the ration during the early stages of these wars. Thomas Lawson who tells us this in 1824 further comments, " . . . but this quantity served only to whet the appetite and to excite the well-known ingenuity of the soldier and sailor in its obtainment."[69] Assistant Surgeon H. L. Heiskell at Fort Brooke in June 1835, after blaming the "intemperate use of ardent spirits" for three fourths of the illness at that post, notes that within a mile and a half of the post there were four different places at which liquor could be obtained.[70]

In 1838 the "spirit-ration" was abolished and coffee and sugar substituted therefore. Although this may have helped a bit, it didn't solve the problem by any means. In March 1839 Assistant Surgeon William S. King at Fort Harlee (Clay County) noted: "Troops suffer more from drunkeness than the effects of climate in Florida . . . and it is the direct cause of nine-tenths of all crimes, desertion and difficulties that occur in the army."[71]

Finally, in the summer of 1841 Lieutenant Colonel B. Riley was sent to investigate reports of drunkeness and disorderly conduct at Fort King (Micanopy, Marion County). He reported to Colonel William J. Worth, the commanding officer in Florida, that he "saw few men sober during my inspection." He approached the respectable inhabitants of the village and suggested they break up the whiskey trade only to be informed that whiskey purveyors outnumbered the other citizens two to one! Riley recommended to Colonel Worth that Fort King be disbanded as the only way to control the drunkeness.[72]

Battlefield Surgery

The beginning paragraphs of this article provide a glimpse of the surgery of the day but a few more comments seems appropriate. In the Seminole War days, the days before the use of anesthesia and the recognition of the germ theory, the chest and abdomen were off limits to the surgeon. Empyemas and abdominal abscesses were incised and drained but only after they had "pointed" and were well walled off. No one dared to enter the chest or abdominal cavity electively to remove or repair a damaged or diseased organ. Thus military surgery primarily consisted of incision and drainage, debridement, wound closure at times, the dressing of wounds and amputations. Looking back on those days one marvels at the courage of the surgeons and the fortitude of the soldiers. An illustrative case is reported from Fort Dallas (Dade County) in August 1841. In his Sick and Wounded report for the month of February 1841 Assistant Surgeon J. W. Russell reports a soldier named Bradley had received a charge of "small shot" in his ankle at a distance of only "a yard or two." This severed the anterior tibial artery and shattered the bones of the ankle and foot. Russell dressed the wound with a "very dilute solution of kreosote" for some weeks and at first the soldier improved. However in August 1841 Bradley began to decline and Russell decided to amputate. His report is as follows: "The operation was performed on the 14th inst. four inches below the knee — It united throughout by the first intention, the ligatures have come away & he is now nearly well & his general health and strength rapidly improving."[73]



Amputating Instruments

Similar cases are reported from other posts and from troops in the field. For example Assistant Surgeon William P. Marshall with the troops in the Big Cypress Swamp performed a midthigh amputation on a soldier whose femur had been shattered by an Indian sniper's bullet. This was done in camp and the soldier was apparently improving when after 48 hours, it became necessary for the detachment to move on. The soldier was placed on a litter and six men were assigned to bear him back to the post hospital at Fort Myers. Along the way the patient sickened and died though we are not given the details.

Another interesting case is given in excellent detail by Assistant Surgeon Richard Clark then at Camp Wacissa, Middle Florida (March 1839):

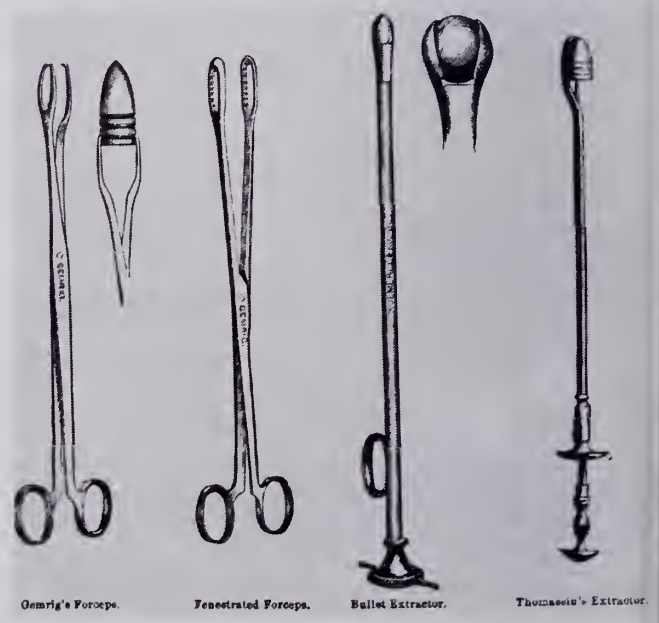
> "Major Nash of the 6th Regt. Infy. was wounded on the 19th February last, by the accidental discharge of his own pistol, the ball Entered his abdomen between the Short ribs and Crest of the ilium of the left side, passing obliquely down posterior to the peritoneum upon the spinal Column. Total paralysis of the left and partial paralysis of the right lower Extremity, bladder and rectum immediately Ensued, accompanied with Neuralgiac pain in his left leg of the most aggravated nature. Upon a Careful Examination of the wound, with a large and long probe, I traced the ball in its Course to the spinal Column, where, from the symptoms, and other Circumstances, I supposed it had imbedded itself. As long as inflammation was present I treated the case upon the strictest antiphlogestic plan with occasional anodynes to allay his suffering. Motion and sensation soon returned to the right lower Extremity, bladder & rectum but more tardily to the left, which now remains partially insensible about the foot and ankle. The wound healed very rapidly, but his sufferings still Continue principally located in the anterior tibial nerve of the left leg. I have kept up Constant Counter irritation over the spine in the lumbar region, with Cups and blisters, and subsequently by the introduction of a Seaton. As soon as partial sensation was restored to the leg, sufficient as I supposed to resist the stimulating effects of blisters, I applied them, and dressed their raw surfaces with the Sulphate of Morphia. He is still suffering greatly from Neuralgia in his left leg, and can only be quieted by large and frequently repeated anodynes."[74]

This was a time in the history of surgery when it was deemed necessary to remove the musket ball if at all possible. Various instruments were designed for this purpose but experienced surgeons preferred to use their forefinger and thumb. Gloves were not in use then and it is likely the hands were not always washed between cases. Bemrose describes the removal of musket balls by his surgeon, Richard J. Weightman, at Fort Drane (Marion County) after the battle of the Withlacoochee, December 31, 1835:

> "Not a wounded man of them had had his wounds dressed from the time they were staunched on the night of the battle, wherefore the morning after our getting home we were extra busy. We commenced at 6 A.M. and finished our work at about 11 A.M. The doctor extracting balls continually, all such as had gone nearly through the body or limb. These were cut out by the scalpel or bituray (bistoury, a lancet). In many it was a sharp practice and not congenial to my nervous system. The grinding of the knife through the sound flesh edged on my teeth but like all matters, the constant tugging and cutting of those balls (for their extrication by the thumb and forefinger was really a tug) caused a sensation of shuddering which gradually wore off . . . Whilst these scenes were being enacted my duty was to stand by with the surgical instruments, needles and so forth, and to finish the bandaging and staunching of blood. After we had completed, I followed the doctor to the general's quarters where my dear old doctor pulled out of his vest pocket the leaden fruits of his morning's labor, counting them in the palm of his hand, at the same time exclaiming, 'General, here are 19 of them. Not a bad morning's work!' "[75]

Tetanus

Tetanus was a severe complication of battle wounds and accounted for many deaths but some survived it. Thus Bemrose records the case of Thos. Caswell who developed severe tetanus but survived after a long and tedious illness. The tetanic contractions were controlled with huge doses of morphia — up to one grain every hour.[76] John W. Malone records the successful therapy of tetanus in a 12-year-old child at Quincy using: enemas, laudanum, copious bleeding, quinine, butter of antimony rubbed the length of the spine and lye and turpentine poultices applied to the wound.[77]



Ball Forceps

Wound Dressing

Wounds were commonly left open and with good reason for they were usually dirty wounds. Sometimes, if the flow of pus was not deemed sufficient, foreign bodies were introduced into the wounds to stimulate pus. Debridement was usually deferred until an eschar was formed. Bemrose describes the debridement of a gangrenous piece of omentum projecting from an abdominal wound.

Wound dressings were often warm poultices or emollient dressings during the acute stages and later cold water dressings. A solution of lead acetate was another favorite wound dressing and, as we have seen, at least one medical officer used a dilute solution of kreosote. Adhesive plaster rather than sutures seemed to have been the preferred method of closing the stump after amputation.

Anesthesia

The discovery of ether anesthesia came just at the end of the Second Seminole War. Oral morphine in the form of laudanum, tincture of opium, and rum or whiskey were frequently given to relieve the pain of surgery.[78] Ether or aether, as it was then spelled, was on the army supply table for oral use in the treatment of diseases of the lungs. However, its initial use as an anesthetic was by W. E. Clarke in New York State in January 1842 for a tooth extraction. Independently on March 30, 1842, Crawford W. Long removed a skin tumor under ether anesthesia at Jefferson, Georgia. On October 16, 1846, William G. T. Morton and J. C. Warren gave the first public demonstration of surgery under ether anesthesia in Boston. Cholorform, which later became very popular, was introduced on November 4, 1847, by Sir James Y. Simpson at Edinburgh.[79]

The single mention of the use of anesthesia during the Seminole Wars which has thus far come to light appears in the Quarterly Report of the Sick and Wounded at Fort Dallas (Dade County) for June 30, 1850. Assistant Surgeon J. L. Adkins reported a soldier who had gotten a fishhook in his hand in May 1850: " . . . the wound was caused by a large fishook passing nearly through the thumb near the articulation of the phalanges. It was cut down upon and drawn through with forceps in the line of entrance. The operation though simple, would have caused much pain, but for the inhalation of Aether, which rendered the patient insensible to pain, though not entirely unconscious of the proceedings."[80] Thus it would appear that as early as May 1850 Dade County was in the vanguard of medicine, if the author may be permitted a chauvanistic comment.

Civilian Practice

Occasionally army surgeons were called upon to deliver a baby. Thus Assistant Surgeon Leonard E. McPhail reporting from Fort Sherrard (Suwannee County) in October 1839 mentions delivering a laundress.[81] Assistant Surgeon Ellis Hughs records the delivery of Mrs. Mulholland's baby boy at Fort Lauderdale (Broward County) on Saturday, April 18, 1840.[82] From time to time the army surgeons and the hospital stewards tended illnesses and injuries among civilian men, women and children, at least in the isolated settlements. According to the journal left by Surgeon Nathan S. Jarvis, army surgeons at this time were allowed to have a private practice and to keep any monies they earned in that fashion, presumably if it didn't conflict with their military duties.[83]

The Summing Up

How then can one epitomize army medical care in Florida during the Seminole Wars? It appears the army surgeons were well trained and very able for their day. The surgery practiced both in the field and in the hospitals was up the best standards of the day. The surgical results achieved were not to be bettered until the introduction of the two great advances, anesthesia and antiseptic/aseptic techniques, some years later.

On the other hand the food ration was deficient in vitamins A, C and nicotinic acid, and possibly in other essential foodstuffs. The food that reached the troops in the field and outlying posts was often inadequate in quantity and not edible. As a result deficiency diseases were prevalent and the soldiers were less able to withstand the onslaught of other diseases. Water supplies were often unpalatable and at times contaminated with organisms bringing the dysenteries, cholera and typhoid. Hordes of insects not only made life miserable but brought life-threatening diseases such as malaria and yellow fever. The twin demons, rum and whiskey, were almost impossible to manage at the army posts and were the cause of accidents, mayhem, murder and physical debility that made the soldiers easy prey for disease. Preventive medicine was in its infancy; indeed, the only available measure other than camp hygiene was smallpox vaccination. This procedure was systematically carried out and effectively prevented smallpox outbreaks among the troops. The medical supplies and equipment were not in short supply and the hospitals were reasonably comfortable and well equipped at least at the more permanent stations. As the sum total result of all these factors, disease killed four times as many men as did bullets.

Precisely how many regulars, volunteers and

militiamen were killed in the three Seminole Wars is not known. Professor Mahon lists 74 commissioned army officers, 1,466 army enlisted men and 69 naval personnel as having died during the Second Seminole War.[84] Of these, 328 of the army deaths and less than a quarter of the navy deaths were from battle wounds. If one uses a figure of 10,169 as the total number of regular armed forces that served in Florida during the Second Seminole War, the mortality for both wounds and disease is about 14%. In addition to the regular armed services it is estimated perhaps 30,000 militia and volunteers served from one time to another during this war. There are no accurate statistics on the number of those who died of wounds or disease — at least 55 were killed in action. Finally, there is no record of how many soldiers died months or years after they left the service of wounds or disease contracted in Florida.

As for the Seminole and Mikasuki Indians, at the outset they were thought to number about 5,000. By the end of 1843, 3,800 had been sent west and an uncertain number had slipped into the vast reaches of the Everglades. It is thought that the Third Seminole War reduced the remnant to less than 100.[85] There is no way of discovering how many of the Indians died of battle wounds and how many died of disease during these wars.

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The Office and Surgery of Dr. James M. Jackson

The City of Miami last year acquired the frame building built in 1905 as the office and surgery of Miami's first physician, Dr. James M. Jackson. The building has survived with a few alterations as a rental property. The Dade Heritage Trust, Inc. and The Ladies Auxiliary of the Dade County Medical Association have set about restoring it to its appearance in the 1905-10 era. A portion of the building will be restored as the doctor's office and surgery complete with furniture, instruments and an x-ray machine (he had one there as early as 1909) of the period. The remainder of the building will serve as the offices of the Dade Heritage Trust and the D.C.M.A. Auxiliary who will serve as guardians and custodians of the museum. Needed are funds for restoration and medical furniture and equipment of the period. Those who will help should contact:

Mrs. Peter Stokley
6944 Sunrise Terrace
Coral Gables, Florida 33133

All contributions are fully income tax deductible.

Dr. Thomas P. Gary
Florida Frontier Physician 1835-1891

Bradford T. Williams, M.D.

In the 1890's, Dr. William Osler was preparing the first edition of his textbook, soon to be the standard text of America and perhaps the world. Johns Hopkins had made medicine a graduate study and was teaching a large part of it through actual work on the wards: a brave new experiment in medical education. Pasteur and Koch had opened the doors of microbiology. Virchow saw his cellular theory widely expanded and now worked on the frontiers of community health. But what of all those physicians who daily toiled in relative obscurity and rendered care to a multitude of patients before these great discoveries?

One such physician, 56-year-old Thomas P. Gary, lay dying June 9, 1891 in the small Florida town of Ocala. The magic of Fleming was not available. Only the sedation of an opiate from the hand of his old friend Dr. William Izlar eased his pain. His last words were, "Goodbye to you and all my friends for I will die." Gary did not live to see what many have called the golden age of medicine. Though he missed one golden age, his life reflected another.

Thomas Porter Gary was born April 10, 1835 in Abbeville, South Carolina. There are few records of his childhood. At 19 Gary apprenticed himself for one year to his brother, Dr. E. F. Gary in Abbeville.

After his apprenticeship Gary went to Philadelphia for a year's study at Jefferson Medical College. In those days a student paid certain fees for each lecture course he wished to attend and in return received pass cards for admission to the lecture hall. Dr. Gary's pass cards are preserved and one is signed by Dr. Joseph Pancoast, the famous anatomist. What a thrill it must have been to study under such a man! Of special interest is Gary's lecture notebook in which he wrote not only his class notes but many personal ones as well. This little book gives a personal glimpse of not only the medicine of the day but also of the man himself.

> "26th Oct. The Clinical lectures of Dr. (Robley) Dunglison 2nd Case. Fits since he was five years old. Coming on every 2 or 3 weeks. They generally come on at night, and are all at once. Entirely insensible. A case of Epilepsy age 19 years. A lesion somewhere in the brain. Oxium zinc 10 grains twice a day can be taken before each meal. Animal food, avoid vegetables. Does not expect much benefit.[1]
> 6 Sept. Surgical Clinic of (Thomas Dent) Mutter and Pancoast 5th Case. Varicose veins. Begin at the toe and apply the adhesive plaster. The limb must be elevated so as to get out all the blood, and wear an elastic stocking. You will find blood ulcers on the projections, these will escar and slough, by this time the veins assume a proper shape. After this apply the adhesive strips and roller bandages. Before they begin to act the patient is put to bed with the limbs elevated. In an hour reapply the roller from the toe, take off the other dressing first."[1]

The discussion of epilepsy and the care of varicose veins have not truly changed that much since Gary's time. One of his first notes, "I have had fresh meat six times since I have been in this city,"[1] written weeks after classes began, strikes a responsive note in all former and present medical students who have had to struggle with short finances and long appetites!

Gary was a typical young man of his time and the back pages of his notebook are filled with young ladies'



Dr. Thomas P. Gary
1890-1891*

*FMA President

names and addresses. In 1855, writing poetry to young ladies was very much the thing to do and a few of Gary's early odes are preserved. One is titled "Tommie:"

"Like some love bird that in a desert drear
Pours forth its melody though none be near
Thus doth my heart its tender tribute pay
Though none may see the brightness of its ray."[1]

Tommie's reply is penciled in, "Oh, thou art treasured in my heart." Tom eventually married Tommie Ann Howell but at that time medicine demanded his entire attention.

In 1856, Thomas P. Gary became Dr. Thomas P. Gary and his diploma is signed by the Jefferson faculty. It is preserved at the University of Florida College of medicine historical library. Of graduation Dr. Gary wrote, "Remember the 14th day of June as the day on which I received my liberty."[1]

From Philadelphia Dr. Gary went to the Medical College of South Carolina in Charleston for another year of study. Afterwards he traveled for a year. His itinerary isn't known but he finally settled in Brooksville, Florida, where he began his first practice. Today Brooksville is a small central Florida town but in 1859 it was a bustling boom town on the edge of a frontier.

The Civil War came to Brooksville as it did to the rest of the nation. Dr. Gary became a surgeon in the 7th Florida Infantry serving in the Western theatre. When the war was over, he returned to Brooksville in 1865. His writings contain no reference to the war he experienced at so personal a level, and so it is that those who have suffered through war find so little to say of it.

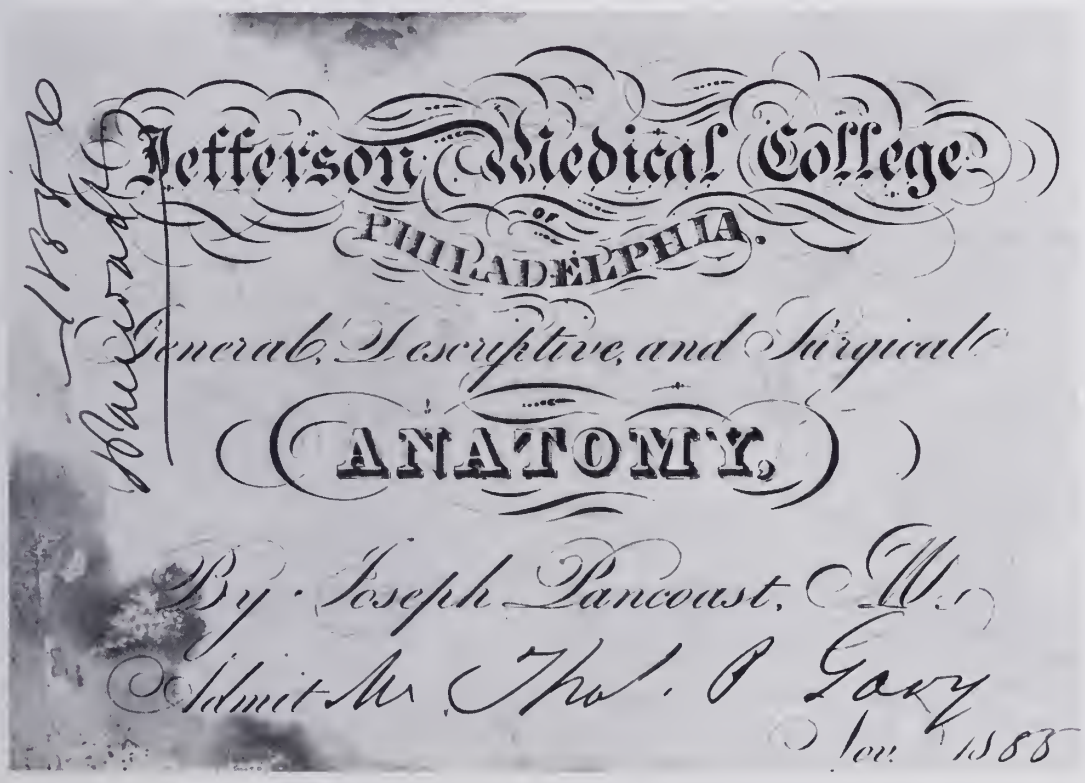
In 1867 Dr. Gary moved to Ocala which became home for the rest of his life. His was following an earlier move by his brother, Colonel Summerfield M. G. Gary, in 1855. Colonel Gary was a respected lawyer who also played a large role in the introduction of orange tree cultivation in that area of the state.

Over the next decade Dr. Gary concentrated on his family and practice. The Garys were blessed with a son, Charles, and a daughter, Annie Rai. The South was broken, poor, and humbled and many men returning from war just gave up; however, Dr. Gary became a leader when leadership was much needed.

Politics and Medicine

On July 25, 1874, Dr. Gary was elected mayor of Ocala, receiving 47 of 66 votes. There was a problem: although he was a Democrat, he was placed on the Republican ballot and knew nothing of the matter until election day! His friend Dr. James A. Ferguson wrote in the next week's paper, "Dr. Gary knew nothing of this and is still a good Democrat. He will do his best for Ocala."[2] Over the next 15 years, Dr. Gary was elected mayor at least nine times. As mayor he was also city judge and one of his more interesting cases involved a five dollar fine for the use of profanity in public.[3]

During this time Dr. Gary became very interested in community health and while mayor in 1887 he formed the City Board of Health. He was immediately elected president and his ordinances were passed: "No hogs



shall be raised in the city limits . . . controls on sewage and drainage . . . requirements for the reporting of a case of smallpox, measles, cholera, or yellow fever . . ."[4] Dr. Gary also formed the county board of health and enlisted surrounding counties in the formation of the South Florida Board of Health. In 1888 and 1889 he was state chairman of the Florida Medical Association's committee on medicine and played a large role in the resolution passed in 1889 urging the legislature to form a state board of health: "We should embrace in any resolutions we may present to the legislature a suggestion strengthening and firmly establishing the board of health with necessary appropriations."[5] This was the birth of the State Board of Health, first directed by Dr. J. Y. Porter.

In 1888 the local boards of health got their real trial by fire: the yellow fever epidemic. Dr. Gary enacted strict quarantine procedures and enforced stringent sanitation controls which probably were responsible for only one case of yellow fever occurring in Ocala while the epidemic ravaged the rest of the state.

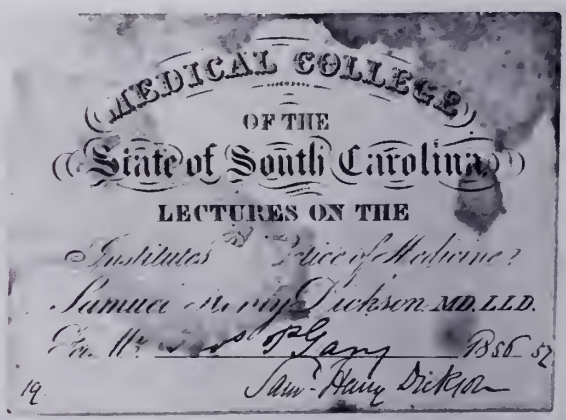
The county medical society met in Dr. Gary's office the second Tuesday of each month and very often he presented a paper. His was an active voice in the strengthening of the profession and his support of the State Medical Examining Board is evidence of his convictions: "The state of Florida is growing in wealth and notoriety and certainly will have in the influx of population many quacks and humbugs whom the people should be protected from by sustaining the Medical Examining Boards in their requirements."[6]

In 1889, when Dr. Gary was first nominated for president of the Florida Medical Association, he read a paper entitled, "Paroxysmal Congestive Hepatic Haematuria." He discussed the care of what appears to be blackwater fever stating:

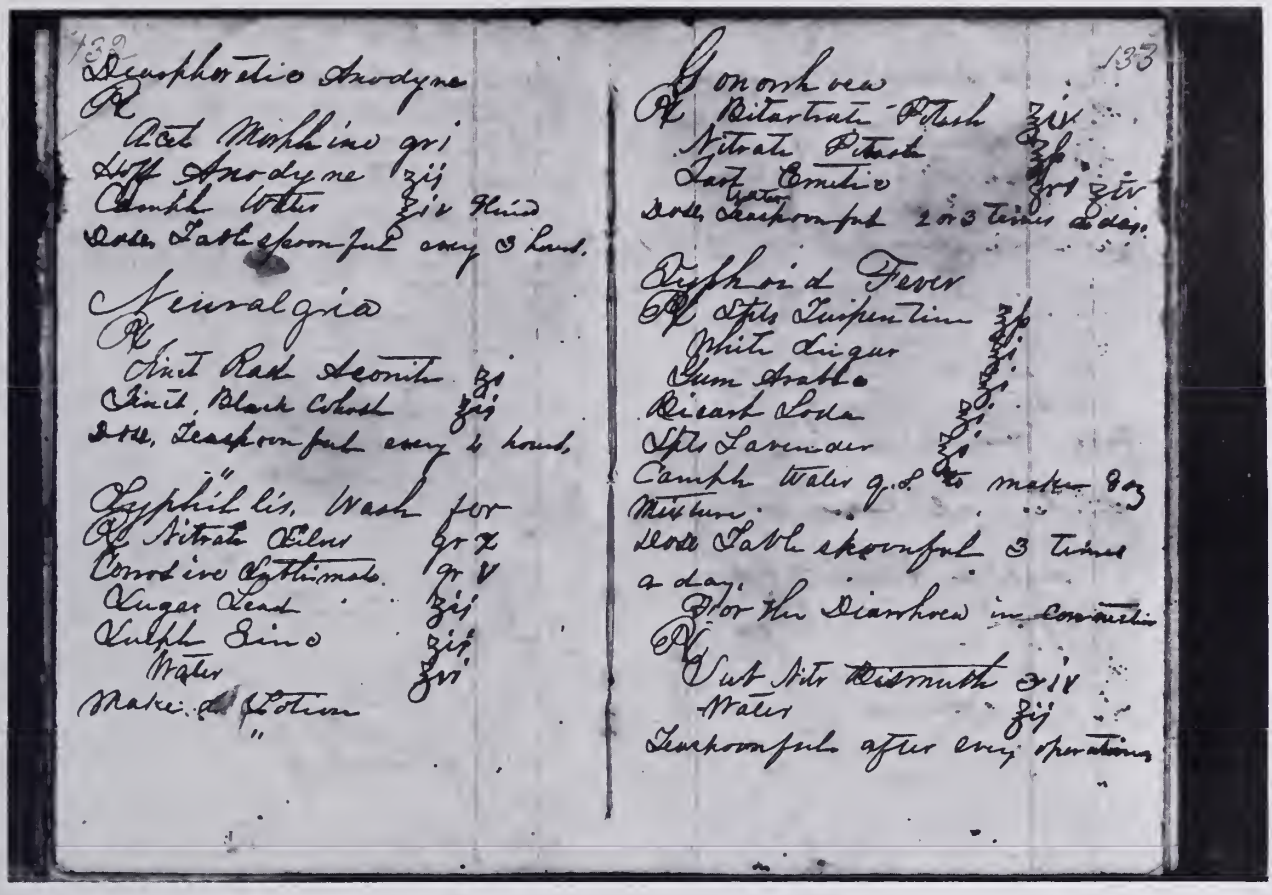
> ". . . apply dry cups to the epigastric and right hypochondriac region with a view to drive the blood from the congested vessels of the stomach and liver to the cutaneous surface and follow the cups, if necessary, by a blister plaster over the same region. To maintain circulation in the skin and to aid in stimulating the liver to excretory action, mustard in bath or applied dry locally to back arms and legs, supplemented by dry heat to the body. The peristaltic actions of the bowels should be assisted and encouraged to action by the free use of enemas of warm water, and sometimes of cold. If the kidneys should fail to excrete urine, use frequent frictions over the lumbar region with warm whiskey and spirits of turpentine . . ."[5]

In 1890 he read a paper at the state meeting titled "The Selection of Remedies." He admonished the young physician concerning the care with which he should select medicine: "I presume there is not one among you who would not rather be the offspring of the humblest woodchopper or sweeper of the streets, if an honest man, than of the most prosperous quack who ever revelled in wealth purchased by a base course of deception, and the cost of injury to thousands."[7] He also said, "Many of these remedies have been discovered, many yet remain concealed to reward future research. Compare the past with the present, and from this comparison infer how much is to be hoped for in the future."[7] Dr. Gary was elected president of the Florida Medical Association in 1890 and in 1891 he was reelected at the state convention in Pensacola.

What of the medical abilities of this man? At the time of his death his library contained more than 120 medical volumes. For the years 1888 and 1889 Dr. Gary was chairman of the medicine committee of the state society. The University of Florida College of Medicine history library has a well worn personal dispensary in which Dr. Gary kept notes of his prescriptions. There were no brand names and each physician had his own special drugs and mixtures and instructions to the pharmacist: from an iron elixer for amenorrhea to a turpentine tonic for typhoid. We can sit back smugly and smile but what will the physician of 2054 think of our treatment for regional enteritis or multiple sclerosis or cancer? One







testament to Dr. Gary's ability is that in 1889 Ocala presented a gold headed cane to him for his many years of service to that community.

In May 1891 the Florida Medical Association convention was held in Pensacola. On the second day Dr. Gary, president, and other members went on a boat tour of the bay. That night Dr. Gary developed a cold but continued to preside at the meetings. In addition to his reelection, he was selected as a delegate to the American Medical Association convention in Washington. He was feeling worse but decided to go to Washington anyway. He made it as far as Atlanta where illness held him. After a few days Dr. Gary decided to go to the home of his brother, Dr. E. F. Gary, to recover. With some improvement, Dr. Gary returned to Ocala the first of June. His condition worsened, however, and he died of pneumonia two weeks later.

In an overgrown abandoned Ocala cemetary there is a plain marker· "Thomas P. Gary — Surgeon C.S.A." and I am reminded of a poem he wrote so long ago in Philadelphia:

> "Farewell! Forget me not when others gaze
> Enamored on thee with their looks of praise
> When weary leagues before thy view are cast
> And each dull hour seems heavier than the last
> Forget me not. May joy thy steps attend
> And may thou find in every form a friend
> With care unsubdued by thy every thought
> And in thy dreams of home forget me not!"

Acknowledgements

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To Dr. Gilles Monif, Professor of Obstetrics and Gynecology, University of Florida College of Medicine, for his helpful criticisms.

To Susan Williams, my wife, for typing and editorial assistance.

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Joseph Otto, M.D.

Mizpah Otto de Boe

When Dr. Joseph Otto died in Key West on June 27, 1885, his death marked a life that had spanned the Atlantic, served the United States as medical officer in war and peace for which his government rewarded him, and left a notable contribution to the practice of medicine as an authority on yellow fever and its treatment. His career was both adventurous and distinguished. He was the first doctor in Florida to found three successive generations of Doctors of Medicine in one family.

Dr. Otto was born in Konigsberg, East Prussia, on July 10, 1826, of noble lineage. He received his degree of Doctor of Medicine from the University of Bonn, Germany.

He had to leave his homeland in the reign of Frederick William IV, King of Prussia, during the "Students' Revolution" in 1848 when Carl Schurz, later a U.S. Senator and Lincoln's Minister to Spain, and other students fled. Schurz escaped to Zurich, Switzerland. Dr. Otto escaped in a load of hay and found passage to London.



Joseph Otto, M.D. (1826-1885)

Driving down a country road near London in his surrey one morning, he saw a little girl about 12 years old who had climbed a fence, lost her footing and was hanging by her petticoat which had caught on a picket. He stopped and lifted her down. She was Maria Elizabeth Belton. When she was 18 he sent for her and she was brought over to the United States by her aunt and they were married in Tampa. The first of their six children, a daughter, Rosetta, was born in Tampa and named for his sister in Konigsberg but called Rose.

Their Aunt Rose and Aunt Hattie told his grandchildren, Robert Eugene Otto and Mizpah Otto, that their father had the Otto genealogy which traced their ancestry directly back to Otto the Great of Prussia who in the 10th century attempted to capture Italy but did not succeed so he went down and married the widow Adelaide, Queen of Italy. These family records and other treasures in the possession of Mrs. Rose Locke were burned in the great fire of May 3, 1901, in Jacksonville, Florida.

Imbued with the democratic ideals of the "Students' Revolution" the 22-year-old surgeon renounced the brilliant prospect of his medical career in Germany to meet the challenge of the new world. From London he migrated to Philadelphia.

As a political refugee, with the necessity of first having to learn the English language, he enlisted as a private in the U.S. Army, giving his occupation as "farmer," at Harrisburg, Pennsylvania, on the 20th day of August, 1849, was sent to Florida the following month and continued in actual service, in the war with the Indians of Florida until the expiration of his term of service. He was private then corporal in Co. L 2nd Artillery then commanded by Capt. Allen Lowd in the regiment commanded by Col. James Bankhead. He served as hospital steward at Fort Brooke (Tampa) and Camp Dunlawton (near New Smyrna). At the latter location Otto contracted intermittent fever (malaria) in the summer of 1853 as is described by Assistant Surgeon Robert Southgate:[1]

> "In connexion with this last paragraph, it may not be irrelevant to mention a case of sickness, characterized by some peculiar features. The greatest sufferer from intermittent fever, during the summer and fall, was

Mizpah Otto de Boe is the widow of Michael Price de Boe, an ophthalmologist and otolaryngologist who practiced in Miami for many years.

Private Otto, hospital steward. The dispensary tent, in which he slept, was pitched just on the border of the marshy plain, described as being immediately in rear of the camp. It was in the centre of a small grove of the cabbage-palmetto, which sheltered it from the rays of the sun. The hospital tent was in front of it, and completely obstructed the current of the sea-breeze; the position was not one of election, but necessity. The physical circumstances in which he was placed, were great dampness, and the rapid growth of a beautiful green mould, that night after night covered the surface of the vegetable extracts. The symptomatical peculiarities of the case were distressing vertigo, and irritability of stomach, which continued throughout the intermissions. He suffered no less than five attacks of the disease, and his case forcibly recalled to my mind several which formed the subject of a communication made to Professor J. K. Mitchell some years since, after a perusal of his lectures on the cryptogamous origin of fever. Had the fungus-producing atmosphere any influence upon Private Otto? If not the cause of intermittent fever, may the unusual development of this form of vegetable life in miasmatic localities be an explanation of the malignity it occasionally displays?"

He was in active service in Florida for five years until his honorable discharge at Fort Mead on the 7th day of August, 1854.

The bald record from the National Archives in Washington fails to give the dangers and hardships of this type of warfare. It seldom records the treacherous Indian outbreaks from ambush in the swamps and jungles of Florida where it took skill as well as courage to survive.



Maria Belton Otto (1841-1894)

.The family does not have record of how long he lived in Tampa after his discharge from the Army. Doubtless his eldest son Lewis, as well as his eldest child Rose, was born in Tampa. His third child Julius, was born in Boston, 1860. It is not known how long he stayed in Boston or for what purpose he was there.

His daughter Rose told it repeatedly in the family that when the Civil War broke out her father's sympathies were with the South and the cause of states' rights. However, it is not known whether he fought for either side and we know he was at Ft. Jefferson, Dry Tortugas, on April 7, 1862, for his name appears on a list of persons permitted to leave Ft. Jefferson on that date.[2] Still other correspondence relating to a request that he be allowed to sell "Spiritous Liquors" upon prescription only at his apothecary shop, the first to be established in Key West, indicates he was in Key West during the period May 1863 to December 1865.[3,4]

It appears that Dr. Otto's life and medical practice in Key West began about April 1862 and continued until his death in June 1885. His life in these years was interrupted by epidemics of yellow fever and smallpox and by periods of service at Dry Tortugas, Indian Key, and at the mouth of the Miami River and Key Biscayne. Records of the Adjutant General's office in the National Archives have disclosed a file of papers relating to the services of Joseph Otto "late Actg. Asst. Surg., U.S.A." as contract surgeon, 1869-1880. He was attached to the Coast Artillery Corps and lived on the post, where his third son, Thomas Osgood, was born. His two youngest children Joseph Jr., who became an eye, ear, nose and throat surgeon, and daughter Hattie M. were also born in Key West.

His record as a contract surgeon follows as an example of the service he rendered:*

July 30, '69	Date of 1st contract
July 30, '69 to Oct. 9, '69	On duty at Indian Key, Fla.
Oct. 9, '69 to Nov. 30, '72	On duty at Key West, Fla. with Co's B & D 3d Art. Post Hosp'l
July 3, '71	Is reported sick with varioloid (mild smallpox)
July 8, '71	Is reported as having genuine variola (smallpox)
July 31, '71	Reports on duty
Nov. 30, '72	Contract annulled

* The contract surgeon in 1866 signed on for three months and received $100 a month at the post and $113.83 if he accompanied the troops in the field. He was expected to have "accessible at all times complete sets of amputating, trephining and pocket instruments."[5]

May 1, '74	Date of new contract for duty at Key West, Fla.
May 1, '74 to June 13, '74	On duty at Key West, Fla.
June 13 to 20, '74	En route to Miami River, Fla. with "I" 1" Art.
June 20 to Aug. 6, '74	Camp W. D. Whiting near mouth of Miami River, Fla.**
Aug. 6 to 9, '74	En route to Key West, Fla.
Aug. 9, '74 to Oct. 18, '74	On duty at Key West Barracks, Fla.
Oct. 18 to 21, '74	En route to Camp W. D. Whiting, Key Biscayne Bay
Oct. 21 to 29, '74	Camp D. W. (sic) Whiting, Key Biscayne Bay, Fla.
Oct. 29 and 30, '74	En route to Key West, Fla. with Co. "E" 1st Arty.
Oct. 30, '74 to Dec. 31, '74	Key West Barracks, Fla.
Dec. 31, '74	Contract annulled
March 30, '75	New contract for duty at Key West, Fla.
Mch. 31 to April 2, '75	En route to Indian Key, Fla. with Co. I, 1" Arty.
Apl. 2 & 3rd, '75	On duty at Indian Key, Fla.
Apl. 5, '75 to June 11, '75	Key West Barracks, Fla.
June 11 to 14, '75	En route to Indian Key, Fla. with Co's E & I, 1" Arty.
June 14 to July 24, '75	On duty at Camp Bell, Indian Key, Fla.
July 25 to Aug. 31, '75	Key West Barracks, Fla.
Aug. 31, '75	Contract annulled
Oct. 1, 1880	New contract for duty at Key West, Fla. to be annulled Nov. 30, 1880
Nov. 30, 1880	Contract annulled

"A territorial government was established in Florida in 1819," wrote Judge William Marvin, "and Key West then began to feel the benefit of an influx of population. Probably few new cities have ever started out with as high a class of population as Key West. Nearly all who came here had some means and were people of culture and refinement. St. Augustine, Virginia, South Carolina, New York and Connecticut furnished their quota of the early population."

By the time Dr. Otto moved his family to Key West about 1862 or 1863 it was known for its spacious homes and charming gardens, its gracious hospitality and fine china and silver service.

**Camp W. D. Whiting was established on William Brickell's property in the spring of 1874. It was on the south side of the Miami River, about 150 yards from the bank and west of Brickell's house which stood at the mouth of the river.

As early as 1835 during the Seminole War a young attorney and former librarian at Transylvania University in Lexington, Kentucky, Charles Walker, spent some time at Key West. While there he wrote two detailed letters to an uncle and aunt, Timothy and Lydia Walker, in his native Concord, New Hampshire.

> "Dear Aunt and Uncle,
>
> At the end of a little coral island, on a sandbar a few feet above the level of the Ocean, stands the city of the wreckers . . .
>
> The society of the place is, of course, small, but there are many families from the Atlantic States now our residents that would be very desirable acquisitions were they to return to the places of their nativity. There is the same taste, luxury and display that you find in the large cities in their dinner and evening parties. More good books, reviews and late publications are found here than you have the most distant idea of."

Dr. Otto's home was a three-storied mansion on Duval Street near Front with the most magnificent royal poincianna tree on the island in his garden. This home and its furnishings, except for a few pieces, were burned in the great Key West fire of April 1, 1886, that began in San Carlos Hall on Duval Street, raged for 12 hours and burned down half the city. Family records, treasures and jewelry saved from this disaster were later burned in the home of his daughter Rose and son-in-law Eugene O. Locke when their home went up in flames in Jacksonville's great fire of May 3, 1901.

His saddle horse was a handsome bay. In later years he made his calls in a buggy driven by William Abbot, a light-skinned Negro from the Bahamas. William was his faithful body servant to his death, attending him when he became blind. Even then he was so meticulous a person he would run his hand over the sheet before getting into bed saying, "William, there's a wrinkle in my sheet." His son, Thomas, cared for William after his father's death and when William died had him buried in the Otto plot in the city cemetery.

His honorable discharge at Fort Mead on the 7th day of August, 1854, describes him at the age of 28 years as five feet, seven inches tall, ruddy complexion, black eyes and black hair. Under "Character" it reads, "Corp. Joseph Otto is a steady, sober man."

Army discharges, of course, have no place for including a man's sense of humour. But there were many instances in Dr. Otto's life that did. His son Tom had borrowed his horse so often to go courting his betrothed that the doctor said, when he rode on his way home, his horse would turn into her street and stop at her gate where he too loved to sit in the saddle and listen to her sweet soprano voice singing favorite songs on soft summer evenings.

Patients loved him for his gentle warmth. His courtesy could beguile you beyond your birthright. His daughter Rose's husband, Eugene Olin Locke, wrote, "He was a polished gentleman of the old school, a man whom it is a privilege to have known."

He was beloved by the community, a distinguished, familiar figure on the streets, making his round of calls on his patients. On the night of his son Thomas's widow's funeral in September 1945, two daughters of his dear friends the George B. Pattersons, Mrs. Freddie Pringle and Miss Etta Patterson, were calling on the bereaved family at the Otto home, 534 Eaton Street. In the living room as they looked up at his portrait on the wall, Mistress Freddie said, "Doctor Otto was the sweet-est man," and Miss Etta, with nostalgic affection said, "Doctor Otto! He brought me into the world."

For a time Dr. Otto served as City Health Officer at Key West. During a smallpox epidemic there in 1872, the navy officials would not permit the use of the United States Marine Hospital so the city constructed two "plain houses" to serve for an isolation hospital under the charge of Dr. Otto. These were soon filled and Dr. Otto had to see patients in the home. The situation is graphically portrayed in a report concerning William Turner who died in that epidemic:

> "The terrible conditions under which patients were nursed is revealed in a report concerning William Turner, who died after the epidemic has subsided and after the hospital had been closed for extra accomodations. The doctor charge ($35.00 for 7 days) is reasonable as he had to go a mile and a half twice a day to see the man. The nurse was ($18.00 per week) cheap at any price as it was almost impossible to procure anyone to attend such cases. Several deaths occurred for want of attentions. Dr. Otto was often compelled to attend personally to the care of the patients, to lay out the dead and in two instances to assist in burial, reading the service by lantern light and filling up the grave . . ."[6]

In his rare leisure hours at home evenings with his books, he smoked a meerschaum pipe with a bowl so large that it took a full package of Bull Durham tobacco to fill it.

An Episcopalian, he was a vestryman of Saint Paul's Church, corner of Eaton and Duval Streets for many years, and could be found on Sunday mornings in his pew with his wife Maria Elizabeth and their six children: Rose, Lewis, Julius, Thomas, Joseph, Jr., and Hattie. His sons' soft-spoken courtesy bore witness to his own and his Prussian discipline. He was wise enough to advise his sons, not abstinence but prophylactic care, of their health against venereal diseases. His daughter Rose was a great beauty. Hattie was an artist. With their mother they had the grace and gentleness of ladies of Key West of that day.

Rose's husband Eugene O. Locke, an attorney and clerk of the U.S. Court to his brother Federal Judge James W. Locke, wrote to the author in July 1929, replying to her inquiry about him:

"As to Doctor Otto, I can give you hardly any information. I am ashamed to say that I neglected taking advantage of conversing with him about a life that must have been interesting and eventful! But I suppose that as a boy I had heard so many adverse criticisms on 'Yankee inquisitiveness,' that I got to 'leaning over backwards,' and have always refrained from questioning.

"But I know he was a polished gentleman of the Old School, and splendidly educated. He had to leave Koenigsberg, Prussia at the time of the 'Students Revolution' in '48 when Carl Schurz and others fled. He was married to Elizabeth Belton who came from near London, with an aunt to Tampa in 1854.

"His history from '48 to '54 I have no knowledge of, nor of the next few years. He was in Boston when Julius was born in 1860. When he located in Key West, I don't know.

"He was at times Health Officer at Key West, and he was year after year contract surgeon, safeguarding the health of the troops. And some summers going with them to the mouth of the Miami River to avoid yellow fever. He was nearly drowned there going down three times.



"He was considered an expert in the treatment of yellow fever and was appreciated at Washington, and a very fine set of medical books was sent him from there which the fire took along with other souveniers." (Another gift from Washington in honor of his work was a silver pitcher, also lost in the fire.)

"He had communication with his kin in Germany for years. My wife was named for his sister and had presents from her — which were also destroyed in the great fire in Jacksonville, May 3, 1901.

"Of his late years he heard nothing from them. Probably the family became extinct. He was a man whom it is a privilege to have known."

When World War II came along his grandson, Thomas Osgood Otto, Jr., was to distinguish himself as chief of surgery of the 305th Station Hospital, then Transit Hospital, in England. Here 11,000 wounded were treated in the 105 days following D-Day and he was to be credited by the Surgeon General of the U.S. as having made in his technique of closure of extensive wounds without grafts[7] the greatest contribution on wound closure to come out of World War II. This grandson made the third generation of physician Ottos in Florida and his grandfather the first physician to found three successive generations of doctors in the state.

Dr. Joseph Otto became blind several years before his death. One afternoon while walking and accompanied by his faithful William, he misstepped wrenching his body. Soon thereafter he had abdominal pain and died several days later possibly of an intussusception. He was 59 years of age.

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● Mrs. Michael Price de Boe, 6901 Yumuri Street, Coral Gables 33143.

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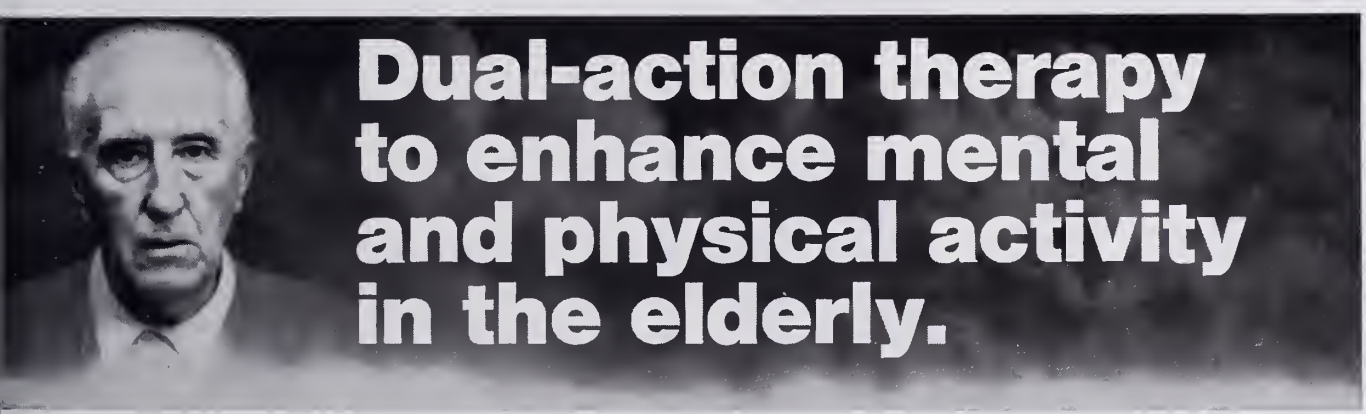
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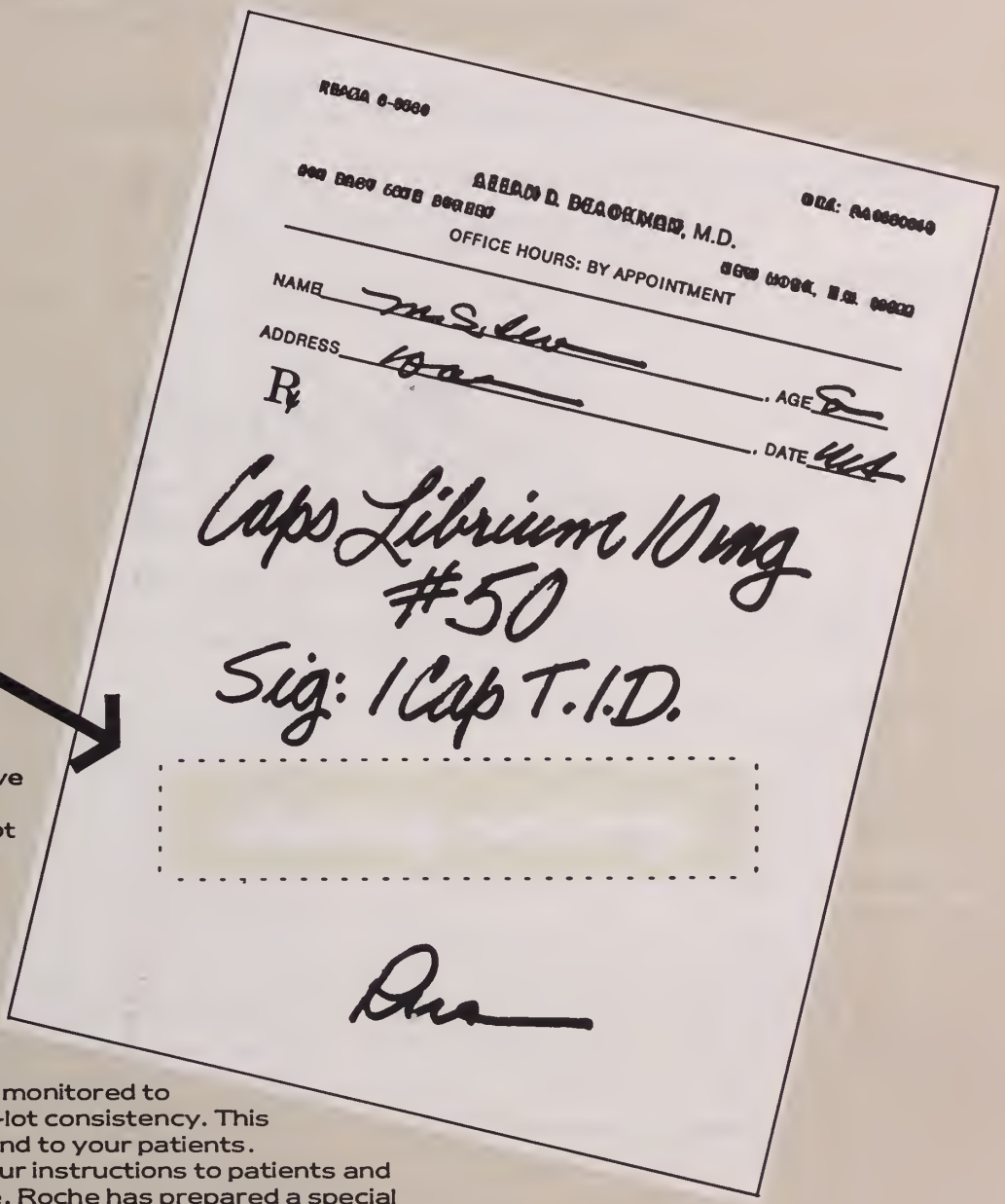
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Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; cause relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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SPECIAL ARTICLE

National Health Insurance

James F. Richards Jr., M.D.

Inflation has accentuated the clamor to reduce the cost of medical care and concurrently has aggravated the problem. Some solutions promulgated by government have intensified inflation such as Medicare and Medicaid and provide further evidence, which history adequately demonstrates, that whatever is done by private enterprise can be done more expensively by government — and eventually is.

The solution to the high cost of medical care is comingled with various proposals for national health insurance by those who think some plan would produce quality care at lower costs. Such efforts are by no means new. The Journal of the American Medical Association reported in 1914: "The socialization of medicine is coming . . . The time now is here for the medical profession to acknowledge that it is tired of the eternal struggle for advantage over one's neighbor." The AMA has changed its direction and leadership but reformers have continued to press for national health insurance.

Franklin D. Roosevelt almost combined health insurance with Social Security in 1935. The brain surgeon, Dr. Harvey Cushing, father-in-law of the President's son, James, may have influenced the President when he wrote: "No legislation can be effective without the good will of the AMA, which has the organization to put it to work." That which Dr. Cushing said 43 years ago still pertains but medicine may be more splintered and divided now than in 1935. It is represented by many groups, no longer just the AMA. A divided profession is vulnerable.

After FDR's New Deal failed to nationalize medicine, Harry S. Truman attempted to pass the infamous Murray-Wagner-Dingell Bill which the AMA treated as "Marxist medicine." Both John F. Kennedy and Lyndon B. Johnson elected to try for less than the total package of national health insurance. In 1965 Medicare and Medicaid provided free or low cost care to the elderly. Immediately a new "health care crisis" was proclaimed. LBJ directed the Congress to do something to combat the "soaring cost of medical care" and "the inexcusably high rate of infant mortality in the U.S. . . ." Later Richard M. Nixon declared: "We face a massive crisis in health care and unless action is taken . . . we will have a breakdown in our medical care system."

The Democratic party platform document of 1976 advocated "a comprehensive National Health Insurance System with universal and mandatory coverage," which means care for all from cradle to grave regardless of need.

Current Legislation

The 94th Congress had 18 bills submitted regarding national health insurance. The titles and verbiage are overwhelming. Perhaps a half a dozen were major, ranging from Long and Ribicoff's "Catastrophic Insurance and Medical Assistance Reform Act," a modest proposal providing health care with exceptionally high costs, to Kennedy's "Health Security" measure proffered since 1969 which would include care for everyone from womb to tomb. All but one of these bills would make health insurance compulsory.

One way of considering these legislative proposals is by category. Mixed public and private include the Ullman bill (American Hospital Association), Burleson-McIntyre bill (HIAA), Fannin bill (U.S. Chamber of Commerce) as well as the Carter, Staggers and Lujan bills. The bills mainly public are the Kennedy-Corman bill supported by the AFL-CIO, Matsunaga bill, Dingell bill, Young bill, and Ketchum-Lagomarsino bill. Those bills categorized as tax credit legislation include Fulton (AMA), Downing, Bennett, Brock, and Clawson. Finally a category of catastrophic protection includes the Long-Ribicoff-Waggoner bill and Roe bill.

Several of these bills have been reintroduced into

Dr. Richards is chairman of the Florida Medical Association's Council on Medical Economics. This article is a condensation of his address to the Escambia County Medical Society in Pensacola March 14, 1978.

the 95th Congress. They seek to make health care available to all, some retaining essentially the present health delivery system and other introducing radical change. Major bills before the 95th Congress include the Burleson-McIntyre (HIAA) HR-5, S-5, Kennedy-Corman (AFL-CIO) HR-21, S-3, and AMA HR-1818, S-218. With a single exception the plans which would provide employment based insurance require the employer to offer the insurance to employees and families.

The Burleson-McIntyre National Health Care Act supported by the Health Insurance Association of America is the only one in which employer participation is voluntary. The employer would have to satisfy certain conditions; provide a qualified plan meeting broad benefit requirements and contribute at least 50% of the premiums. If the program failed to meet these conditions, he would lose the income tax deduction for premiums paid. The employee would pay no more than 50% of the premium; low income individuals or families would pay less and a family of three or more with an annual income of less than $4,000 would not contribute. The individual having "qualified" insurance would claim the full amount of the premium as an itemized income tax deduction. The deduction limit of premium under 3% rule would not apply.

The state would contract with carriers which would act as intermediaries to pay health care costs for the needy. Premiums would be determined on the basis of income and family size.

Benefits would include diagnostic tests, well child care for those under age five, oral and eye examinations for those under age 13, and prenatal examinations. These items would be exempt from deductible and co-payments. In another category benefits would be subject to deductible and co-payment and would include such things as psychiatric care, 50% covered. Cosmetic surgery and personal comfort items would be excluded.

The Kennedy-Corman bill, otherwise known as the Health Security Act, significantly similar to the British system, emphasizes public financing or a national health service. Funds would be created through Social Security taxes for half the cost and through general revenues for the other half. Participating physicians and other providers would be under contract to the federal government. Coverage would be through capitation; individuals and families enrolling in a group practice or with a primary physician one year at a time. Care would be provided within a stated schedule of benefits and services of specialists upon referral by the primary physician.

The country would be divided into regions and health care service areas with local offices and branches. Services would be provided within a fixed budget. Employers would pay a 3.5% payroll tax, wage earners 1% tax on salary, and self-employed persons a 2.5% tax. The budget could not exceed estimated receipts from special taxes and matching funds from general revenue. Services would be reduced proportionately to come within the budget and avoid exhaustion of funds before the end of the year if that became necessary. Primary physicians could elect to be paid by capitation. Physicians could also elect to charge fee for service. When deemed necessary by the five-member Health Security Board appointed by the President in order to assure availability of services or for other reasons, that Board could pay a practitioner a salary or stipend in lieu of, or as a supplement to, capitation or fee for service.

The AMA plan, Comprehensive Health Care Insurance Act of 1977, provides full coverage for all through private insurance, employment based insurance paid by employer-employee, continuing insurance for the temporarily unemployed, and income related premium subsidy on insurance for the nonemployed and self-employed. It would require employers to furnish health insurance for their employees and families. Individuals having employment based insurance would continue with it. Federal, state and local governments would fall within the definition of employer. The coverage would provide full protection against ordinary and catastrophic expenses of illness and the employer would pay at least 65% of the premium, the balance being paid by the employee.

Coverage for nonemployed and self-employed persons and the elderly would include federal contribution to the cost. They would purchase insurance or a plan of their choice, either pay the full premium and claim a tax credit or arrange to pay only their share, if any, and have the insurance company bill the government for the balance. The government share in the premium would be determined on the basis of the income tax liability of the individual or family in the year preceding the purchase. For instance, a family of four with $7,150 income resulting in a $156 tax liability would be entitled to 84% of the premium paid by the federal government. The elderly would continue to have Medicare but would be eligible to purchase supplemental coverage, bringing their insurance protection up to benefit level of the under 65 population.

Benefits would include as many as 100 days of inpatient care a year in a skilled nursing facility and all medical care provided by or under the direction of a physician including inpatient and outpatient psychiatric care as well as preventive services. Children under seven would be fully covered for dental care; ultimately this limit will be raised to include all those under 18 years of age. Adults would be covered for emergency dental care only.

There would be a coinsurance factor of 20% with the poor exempt. Regardless of income the coinsurance ceiling would be no more than $1,500 for an individual or $2,000 for a family. Coinsurance has the advantage of cost sharing and would tend to prevent policy holders from demanding care just because it is paid for or hospitalization because of convenience.

State government would perform administration with guidelines established by a 15-member Health Insurance Board. Reimbursement would be made for a physician's services at usual and customary or reasonable charges as calculated on a "current basis." Institutional reimbursement would be based upon prospective budgeting and other alternative methods, no one method necessarily applying exclusively to all institutions.

The Board would regulate administration of health services, establish national insurance regulations, and enforce those on state insurance departments. It would establish national health care standards, allocate all monies available for health care and would be authorized to allocate health manpower and health facilities in the nation. The Board would be given authority to educate, even down to the local systems.

Comment

The Louisiana State Medical Society has prepared a meticulous evaluation of the 42-page AMA bill. Some comments are appropriate.

The bill includes compulsion and implies that health care is a right. Increased employers' cost would cause inflation. Part-time employment and minority and teenage employment might be discouraged. Claims for deductions would overwhelm the capacity of the Internal Revenue Service. Fraud would be encouraged; bureaucracy would increase. The legislation would lead to price fixing, overutilization and manpower maldistribution, and medicine would become subject to political manipulation. Competitive health insurance would be ended and health care standardized.

The AMA has been criticized for introducing the legislation. Perhaps it is pragmatic to conclude that such legislation is inevitable, realistic to assume that the least restricted bill will be the best in the end. Neither the AMA bill nor the other bills are likely to improve the quality of health care, and each would increase the cost of medical care.

The majority of physicians are opposed to any kind of national health insurance, certainly to a kind that would apply to all people regardless of need. At the same time physicians recognize that issues are decided by democratic vote. Forces such as organized labor are demanding that some form of national health insurance be adopted and have become more active in their efforts to control national and state legislatures. Labor is the largest organized proponent and as in England may ultimately contribute to socialization in this country beginning with organized medicine.

At this time it is popular for people to want something for nothing, to envy the larger house, the larger car. The medical profession traditionally has presented the facade of wealth, whether physicians are individually wealthy or not, and it matters little because society thinks they are. When an issue like national health insurance goes before voters an emotional issue is their concept of physicians in general. Many people think they make too much money for too little input. The years of training, hours worked, dedication and compassion seldom are considered.

The Columbia Broadcasting System reported in December 1976 that 36.6% of the people supported national health insurance. In 1975 the Roper poll had found 41% favorable. If these figures are correct, perhaps the American consumer feels just as the American physician. If, however, the consumer eventually decides that he wants national health insurance, it will become a fact of life. The people then may be disappointed to find that what they have obtained is something akin to sick bay in the military.

● Dr. Richards, 1315 South Orange Avenue, Suite D, Orlando 32806.

Find out what you want to do, then do it!
It is boredom that wears a man down,
Not the fatigue of sustained effort he enjoys.

F. Alexander Magoun

ORGANIZATION

Duval County Medical Society Celebrates 125th Anniversary

A page of history was relived on May 25 when scores of members and guests gathered on the spacious riverfront grounds of the Duval County Medical Society in Jacksonville to observe the organization's 125th anniversary.

First, there was a ceremony and program marking the relocation of the Dr. James Hall Memorial to the Society's lawn. Then the guests attended the Society's 125th Anniversary reception.

The Hall Memorial consists of the late physician's headstone and an attractive historical marker affixed to a concrete slab and enclosed by a fence of wrought iron. The stone had been relocated from the Hall grave site at Mandarin where it had been the target of several acts of vandalism over the years. Once it was stolen but recovered later in a park in Jacksonville several miles away.

Dr. Hall, one of the earliest of Florida physicians, was born in 1760 and lived for 77 years. He is said to be the only combatant of the American Revolution buried in Duval County.

Robert H. Threlkel, M.D., President of the Academy of Medicine of Jacksonville, presided at the relocation ceremony. Participating in the unveiling of the memorial and giving brief commentaries on Dr. Hall were: Mrs. Ray O. Edwards Sr., Past Regent of the Jacksonville Chapter of the Daughters of the American Revolution; Col. William S. Hutchinson, President of the Jacksonville Chapter of the Sons of the American Revolution; and G. Dekle Taylor, M.D., a Past President of the Duval County Medical Society.



The gentleman at the left is neither an undertaker, a minister nor a reincarnated founder of the Duval County Medical Society. He is Clyde M. Collins, M.D., of Jacksonville, an editor of this Journal for several years appearing here as Chairman of the 125th Anniversary Committee of the Duval County Medical Society. He and Mrs. Guy Selander look on approvingly as Robert K. Middlekauff, President of DCMS, prepares to make the first fracture in the anniversary cake.



Participating in ceremonies marking the relocation of the Dr. James Hall Memorial are (left to right): Robert H. Threlkel, M.D., President of the Academy of Medicine of Jacksonville; Col. William S. Hutchinson, President of the Jacksonville Chapter of the Sons of the American Revolution; Kenneth Morris, M.D., who served as President of the Duval County Medical Society in 1937; and Mrs. Ray O. Edwards Sr., Past Regent of the Jacksonville Chapter of the Daughters of the American Revolution.

FMA Film "It's Your Life . . ." Wins Contest Award

The Public Relations Department of the Florida Medical Association was recently awarded first place honors in two separate contests.

The FMA film, *It's Your Life . . .* was chosen to win one of the Florida Heart Association's Steve Yates Media Awards for its contribution toward a better public understanding of the cardiovascular system.

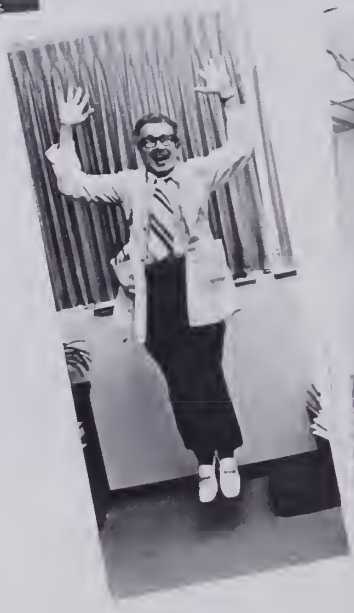
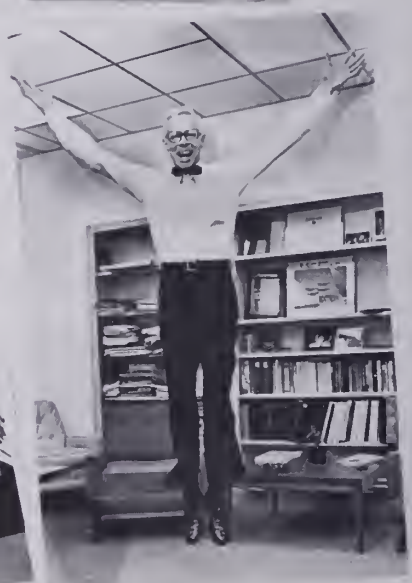
The Southern Public Relations Federation presented its annual Lantern Award to FMA for the production and writing of the bi-monthly *Medical Message* column. The column is distributed to print media outlets in the state and deals with health topics of general interest.

In addition, *It's Your Life . . .* was one of the films featured at the Biennial John Muir Medical Film Festival in June in California.










First Row from left to right: Emanuel M. Papper, M.D., Vice President for Medical Affairs and Dean, University of Miami School of Medicine; Edward W. D. Norton, M.D., Professor and Chairman, Department of Ophthalmology; Michael S. Gordon, M.D., Clinical Professor of Medicine and Cardiology; Joseph H. Davis, M.D., Professor, Pathology; Peritz Scheinberg, M.D., Professor and Chairman, Department of Neurology; and Alfred Ketcham, M.D., Professor of Surgery and Chief, Division of Surgical Oncology. Second Row: Joe U. Levi, M.D., Assistant Professor of Surgery; Henry King Stanford, Ph.D., President of the University of Miami; George A. Tershakovec, M.D., Professor of Biochemistry; Eugene R. Schiff, M.D., Professor of Medicine, and his father, Leon Schiff, M.D., Clinical Professor of Medicine and Hepatology; Nancy Fawcett, M.D., Associate Professor of Pediatrics; Karl H. Muench, M.D., Professor of Medicine and Biochemistry and Chief of Genetic Medicine; William Whelan, M.D., Chairman, Department of Biochemistry. Third Row: Eric Reiss, M.D., Professor and Vice Chairman, Department of Medicine; John K. Robinson, M.D., Associate Dean for Student Affairs; and Frank E. Bishop, M.D., Assistant Professor of Psychiatry and Assistant Dean for Student Affairs.

JUMPING FOR JOY?

. Well, not exactly. Ron Cassel Jr. and Don Temple, editors of the 25th anniversary edition of the SYNAPSE, The niversity of Miami School of Medicine's yearbook, asked the faculty to jump for their camera. Cassel and Temple rrowed the idea from Philippe Halsman, one of the world's foremost photographers, who invented "jumpology," the ngue-in-cheek analysis of personality from the way a person jumps. Even the Dean of the medical school, Emanuel pper, M.D., got into the spirit of jumping. The SYNAPSE chose to undertake this project in honor of the School of dicine's Silver Anniversary to demonstrate that their mentors do indeed have personalities which are full and often ferent from what might be expected. While the jump can not be totally revealing, it can indicate some surprising ndencies of a person's personality.

Dr. and Mrs. F. Eugene Tubbs Perish In Lake City Plane Crash

Frederick Eugene Tubbs, M.D., a former member of the Florida Legislature, and his wife, Carole, were killed on July 4 in the crash of their single engine private plane near Lake City, Florida.



Dr. Tubbs

Dr. and Mrs. Tubbs, 42 and 39, respectively, reportedly were on a flight to their home in Brevard County when they encountered a thunderstorm and crashed during an attempted emergency landing.

Dr. Tubbs had recently received a law degree from Florida State University and was preparing to enter the practice of law in Brevard County. He entered law school after failing in his bid for the Republican nomination for State Treasurer and Insurance Commissioner in the 1974 primary election.

Dr. Tubbs practiced internal medicine in Rockledge for several years before running for a two-year term as a Republican in the Florida House of Representatives in 1970. He was voted the most outstanding first-term legislator and was re-elected to the House in 1972.

In his four-year legislative career, Dr. Tubbs was prominently associated with many legislative issues including emergency medical services, children's medical services and physician's assistants.

In 1974, the Florida Pediatric Society honored Dr. Tubbs for his leading role in the successful effort to create a Division of Children's Medical Services within the Florida Department of Health and Rehabilitative Services.

During his relatively brief but illustrious career, Dr. Tubbs also was a member of the small group that developed the well-known drink Gatorade at the University of Florida; and served as a flight surgeon for the Gemini astronauts.

Born in Dania, Florida, Dr. Tubbs attended the University of Florida during 1954-57 and received his M.D. degree from Emory University in Atlanta in 1961. He served an internship at the University of Florida beginning in 1961, served as an Air Force Captain in Gemini program in 1963-65, and returned to the University of Florida for residency in 1965-67.

Dr. Tubbs was a member of the Brevard County Medical Society and the Florida Medical Association but transferred his membership to the Capital County Medical Society when he entered law school.

Dr. and Mrs. Tubbs leave four children, ranging in age from four to 19.

There are some problems that have no solutions.
There are some problems that must simply be lived through.
Survival calls for the ability to sustain the tension without fight or flight.

Sydney J. Harris

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5. The worth of character.
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7. The influence of example.
8. The obligation of duty.
9. The wisdom of economy.
10. The virtue of patience.
11. The improvement of talent.
12. The joy of originating.

Marshall Field

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Book Reviews

Book Review Editor.
F. Norman Vickers, M.D.

General Ophthalmology by Daniel Vaughan, M.D., and Taylor Asbury, M.D. 379 Pages. Price $12.00. Illustrated. Lange Publishers, Los Altos, California, 1977.

General Ophthalmology, written for medical students and general practitioners of medicine, provides a good summary of the diagnosis and treatment of ocular disease that can be used by residents and practicing Ophthalmologists as well. The text is characterized by a practical, common sense approach to ocular disease as demonstrated on the inside of the front and back covers of the volume. The former has a chart on the differential diagnosis of the red eye, a problem frequently encountered clinically; and the back, a list of abbreviations commonly used in Ophthalmology. In the chapter — Examination of the Eye — the authors thoroughly discuss history taking, symptoms of ocular diseases and the examination. Commonly used tests, some not included in previous editions, are given. The only criticism that I have of this text is that in the chapter on examination, no reference is made to the extensive and helpful review of direct ophthalmoscopy found in the first appendix.

Pictures of equipment, techniques of examination, clinical appearance of a number of eye diseases, histological sections, and diagrams of the principles of general optics amply illustrate the text. Although the quality of reproduction of some of the clinical photographs is poor, the pathological conditions are easily seen. The chapter — Principles of Management of Common Ocular Disorders — succintly lists the first steps in the treatment of acute ophthalmological conditions as well as underscoring the pitfalls in therapy to be avoided by the non-ophthalmologist. The subject matter covers all aspects of ophthalmology from the most common such as conjunctivitis (the section was thoroughly revised) to rare conditions with ocular manifestations as Wegner's granulomatosis. The overall organization of the text is excellent, giving an appropriate amount of space to subjects of most interest to the readers and providing pertinent and short reviews on material such as optics and refraction that is vitally important to the ophthalmologists but less so to the medical students. Subjects on intraocular lens, vitrectomy, laser therapy and corneal transplants that receive publicity in the lay press are touched on briefly and concisely, and the information will be useful to family practitioners who are often asked about these topics.

The revised text contains three new chapters — Sclera, Blindness and Immunologic Disease of the Eye — and an appendix — CT Scan in Ophthalmic Diagnosis — all noteworthy additions. Those who work with the blind or poorly sighted and have searched for statistics on blindness that are often buried in technical reports will find the new chapter a welcome and invaluable reference. The discussion on CT scanning provides basic information for the clinician. Ophthalmic assistants and nurses in offices and emergency rooms can use this text as a handy, concise, practical and readable reference in their work.

In general, this book should be one of the most widely used handbooks of Ophthalmology today. It is eminently practical for physicians who deal with ocular problems. The authors are to be congratulated.

Elise Torczynski, M.D.

Dr. Torczynski is Assistant Professor, Department of Ophthalmology, University of South Florida, Tampa.

Register To Vote!

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Labor & Delivery, An Observer's Diary by Constance A. Bean with an introduction by Gerald Cohen, M.D. 203 Pages. Price $7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Occupational Diseases: A Syllabus of Signs and Symptoms by E. R. Plunkett, M.D. 352 Pages. Price $22.50. The Barrett Book Company, Stamford, Connecticut, 1977.

DNA Repair Processes, Edited by Warren W. Nichols, M.D. and Donald Murphy, Ph.D. 286 Pages. Illustrated. Price $29.95. Stratton Intercontinental Medical Book Corporation, New York, 1977.

Chelation Therapy in Chronic Iron Overload, Edited by Edward C. Zaino, M.D. and Richard H. Roberts, M.D. 140 Pages. Illustrated. Price $17.95. Stratton Intercontinental Medical Book Corporation, New York, 1977.

The Health of the People. 140 Pages. Illustrated. Chris van Rensburg Publications (Pty) Ltd., P.O. Box 25272, Ferreirasdorp, 2048, Johannesburg, Republic of South Africa, 1977.

Annual Review of Neuroscience with 28 contributing authors. 506 Pages. Illustrated. Price $17.00. Annual Reviews, Inc., Palo Alto, California, 1978.

Heart Attack! A Question & Answer Book by Oscar Roth, M.D. with Lawrence Galton. 262 Pages. Price $8.95. Lippincott, New York, 1978.

Pharmacological and Toxicological Perspectives of Commonly Abused Drugs by Darryl Inaba, Ph.D., E. Leong Way, Ph.D., Kenneth Blum, Ph.D. and Sidney H. Schnoll, M.D. 44 Pages. National Drug Abuse Center, Rosslyn, Virginia, 1978.

Review of Medical Microbiology, 13th Edition by Ernest Jawetz, M.D., Joseph L. Melnick, Ph.D. and Edward A. Adelberg, Ph.D. 550 Pages. Illustrated. Price $12.00. Lange Medical Publications, Los Altos, California, 1978.

Currents in Alcoholism, Biological, Biochemical, and Clinical Studies, Edited by Frank A. Seixas, M.D. 601 Pages. Illustrated. Price $31.50. Grune & Stratton, Inc., New York, 1978.

Controlling the Use of Therapeutic Drugs: An International Comparison edited by William M. Wardell. 263 Pages. American Enterprise Institute for Public Policy Research, 1978.

Medical Artifacts Collection at the University of Florida

As part of the growing program in medical humanities at the University of Florida College of Medicine, the Division of Social Sciences and Humanities is now offering courses, noon-time discussions, formal lectures, and spot teaching sessions on topics in the history and philosophy of medicine. Todd L. Savitt, Ph.D., a medical historian at the Health Center, is currently building a medical artifacts collection to demonstrate the ways in which medical thought and technology have changed over the years. At present the collection is quite small: a spring lancet, a glass cupping set, a set of craniotomy instruments, and a few assorted surgical tools. Shown in conjunction with slides illustrating their use, these instruments provide students with a real sense of the medical past not otherwise attainable. Savitt is anxious to expand this teaching collection both in breadth and depth. If you own or know the location of old medical instruments, and are willing to lend or donate them for educational purposes to the University of Florida College of Medicine, please contact Dr. Savitt at the following address.

Todd L. Savitt, Ph.D.
Department of Community Health and Family Medicine
Box J-222
J. Hillis Miller Health Center
UNIVERSITY OF FLORIDA
College of Medicine
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"Differentiation between supraventricular tachycardia with aberrant conduction and ventricular tachycardia"

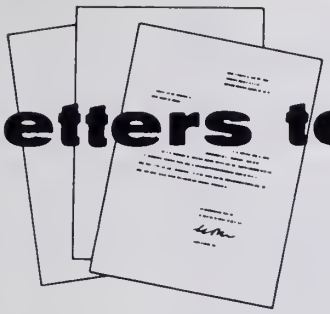
Thursday, September 7, 1978 at 7:30 PM
"Electrocardiogram and Digitalis intoxication"

Friday, September 8, 1978 at 7:00 PM
"Atrioventricular and intraventricular conduction disturbances in acute myocardial infarction"

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Letters to the Editors

MEDICAL PRACTICE ACT AMENDMENT EXPLAINED

To The Editor: The Medical Practice Act was amended by the 1978 Legislature to allow prompt disciplinary action by the Board of Medical Examiners (BME) against a physician who is professionally incompetent. The bill provides that when an organized medical staff charges a physician with immoral or unprofessional conduct, incompetence, negligence, willful misconduct, or the failure to conform to the standards of acceptable and prevailing medical practice in his area of expertise and in the opinion of the director and two members of the board the evidence is clear, competent and unequivocal, the director of the BME *shall* enter an order temporarily suspending the physician's license to practice medicine, without hearing, pending a full hearing. The suspension order may be entered prior to the filing of a complaint. The full hearing by the BME must be held within 60 days from the date of the suspension order.

The term organized medical staff means the formal organization of physicians or other health care providers organized under and responsible to the governing authority of a hospital, HMO or ambulatory surgical center for the quality of all medical care provided to patients in the hospital, for the maintenance of proper standards of medical care, and for ethical and professional practices of its members.

The legislature has now provided the members of the medical profession through the BME with the authority to deal promptly and effectively with those members of the profession who are deficient, who do not measure up to expected standards and who do not deserve the privilege to continue practice.

It is the duty of our profession and all organized medical staffs to accept this responsibility and forthwith and unhesitatingly from this time on charge those amongst us who should be charged so that the BME can perform its obligation for the protection of our citizens as defined in the Purpose of the Medical Practice Act and the BME, Florida Statutes, Chapter 458.001. To do any less will be a failure on the part of the medical profession to deserve the confidence and trust placed upon and within us.

George S. Palmer, M.D.
Executive Director
Florida Board of Medical Examiners
Tallahassee

(Editor's Note: Dr. Palmer's memorandum was addressed to all licensed hospitals, Health Maintenance Organizations and Ambulatory Surgical Centers.)

IN APPRECIATION

O. William Davenport, M.D.
President
Florida Medical Association
Miami

Dear Dr. Davenport: The Florida Medical Association honored me greatly with the Certificate of Appreciation. I was humbled by it for so little, if anything, has been accomplished in improving public health programming over the past four years. I and the programs I represent are not worthy of such distinguished recognition.

Humbling particularly was the implication through such a presentation that I might be "tall enough" to be seen by the FMA. Any truth in such a suggestion would stem entirely from the height and strength of those upon whose shoulders I stand. Dr. Wilson Sowder, for example. It was he who nurtured my career in public health. And, Dr. Albert Hardy who was entirely

responsible for my decision to enter medical school and choose public health as a specialty. Thad Moseley, Sy Doff, Sy Sharp, Dean Steward, George Palmer, Jim Walker, Gene Flipse, Gerry Schiebler, Carl Brumback, Jim Fulghum, and Harold Parham, all distinguished members of this Association hold me firmly on their shoulders. In appreciation to them, and the scores of others who now or have in the past held me up, and in their name, I accepted the Certificate in appreciation.

Truely, I thank you for the recognition of us all and express my personal gratitude that I was chosen to represent the group at the presentation ceremony.

E. Charlton Prather, M.D.
Staff Director
Health Program Office
Tallahassee

HOSPITAL COSTS

To the Editor: I think the article in the June issue of the FMA Journal in regard to why hospital costs are so high is tremendous. I think it should be printed in a format of a type that doctors can leave on the tables in their waiting rooms for patients to look at. I think this will give the average person a much better feel for what is going on in the field of regulations of hospitals and a feel for what Government is doing to us.

Congratulations on a tremendous issue of the FMA Journal. The picture of Dr. Davenport and all of the articles throughout I have found extremely good.

With kindest personal regards.

Charles F. Tate Jr., M.D.
Chairman, FMA/HSA Committee
Miami

THANKS TO ALL

To: W. Harold Parham, D.H.A.
Executive Vice President
Florida Medical Association
Jacksonville

Dear Harold: Please convey my deepest gratitude to all the members of **The Board of Governors** for the wonderful honor bestowed upon me Saturday, May 6, 1978 during the sessions of the Florida Medical Association's 104th Annual Meeting.

As acceptable as this honor is, I would be an ingrate if I did not share the honor with others who helped me attain it. First of all, I merely did what I was supposed to do and the resolution is icing on the cake. My wife is trying to validate all the qualities as spelled out in the resolution and she is spoiling me more than usual since the occurrence. I was assisted in all my work by a wonderful team composed of Hal Parham, Ed Hagan and John Thrasher who implemented the policies as laid out by Bill Thompson, Vince Corso, Jim Winslow and Joe Davis. I was inspired at the onset, as Chairman of the Judicial Council by our mutual friend and savant Homer Pearson. All these deserve the real credit and I shall end by saying I was glad to be helpful in performing a job that needed doing and did the best I could at the time. My cup runneth over and I shall look forward to our continued friendship and watch the development of the Florida Medical Association which, to me, is an outstanding institution in my estimation.

With kindest personal regards and love to Mary.

John Cheleden, M.D.
Daytona Beach

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The Continuing Medical Education programs . . . of one FMA-recognized specialty group and two community hospitals in Florida have been accredited by the Liaison Committee on Continuing Medical Education (LCCME).

According to Ralph E. DeForest, M.D., of Chicago, Secretary of the LCCME, full three-year accreditation was awarded to: Florida Academy of Family Physicians; Tallahassee Memorial Hospital, Tallahassee; and Cedars of Lebanon Health Care Center, Miami. The three agencies were resurveyed by representatives of the FMA Committee on Continuing Medical Education toward the end of their one-year provisional terms.

Accreditation denotes that the organization conducts continuing medical education of exceptional quality. Accredited organizations are authorized to sponsor or co-sponsor CME programs offering American Medical Association Category I Credit.

The LCCME is the nationally recognized accrediting agency for continuing medical education programs. It assumed that function from the AMA in 1977.

For several years, the FMA Committee on Continuing Medical Education has conducted accreditation site visits in Florida for the AMA and LCCME.

Joel A. Schneider, M.D., of Hollywood . . . has been elected President of the Greater Miami Radiological Society. Other new officers for 1978-79 are: Neil H. Messinger, M.D., Miami, Vice President; Phillip P. Gassman, M.D., Miami, Secretary; and John J. Pittari, M.D., Ft. Lauderdale, Treasurer.

The society meets on the third Wednesday of each month at Cedars of Lebanon Health Care Center in Miami.

Victor A. Politano, M.D., of Miami . . . has been elected to high office in two urological organizations.

In April, Dr. Politano, Professor and Chairman of the University of Miami School of Medicine's Department of Urology, was elected President of the Southeastern Section of the American Urological Association at a meeting in Louisville. Two months later, Dr. Politano was designated as the new President-Elect of the Society of Pediatric Urology at the group's annual meeting in Washington, D.C.

Two former top-level administrators . . . at the University of Miami School of Medicine have been designated Honorary Alumni of the School.

The designation of Robert T. Spicer, M.D., and John J. Farrell, M.D., as Honorary Alumni were announced at the Fifth Annual Paff Seminar Banquet.

Dr. Spicer, then a well-known obstetrician and gynecologist in Miami, was named Miami's first fulltime Medical School Dean in December, 1953. He stepped down for health reasons in July 1954, and now lives on Sanibel Island.

Dr. Farrell, now of Lake Worth, was the School's first Professor and Chairman of Surgery. He served from August 1955 until he resigned in 1962 to enter private practice.

Gerold L. Schiebler, M.D. . . . Editor of *The Journal*, has been elected to the Advisory Committee of the State Medical Journal Advertising Bureau (SMJAB).

The Committee counsels the SMJAB Board of Directors in its national efforts to sell advertising space in JFMA and 33 other state medical journals. The Board unanimously elected Dr. Schiebler to the post at its meeting in St. Louis in June.



Others Are Saying

Capsuling History . . .

Cristoforo Colombo: East by West

Cristoforo Colombo, who called himself Cristobal Colon in Spain and who in English is known as Christopher Columbus, was born in 1451 in Genoa, then the capital of an independent Italian Republic.

Columbus conceived a great enterprise while working as a chart maker in Lisbon, Portugal. He proposed reaching "The Indies," Eastern Asia, by simply sailing west. The idea was not new, people had been talking of doing that since the days of the Roman Empire. No one had wanted to test the theory prior to Columbus as the ocean was reported too broad and the winds too uncertain to carry cargo and crews for unknown periods of time.

Columbus believed that Cipangu (Japan) was only 3,000 nautical miles west of Lisbon and by sailing 2,400 miles west along the latitudes of the Canary Islands he would reach a group of islands near Japan. He had the persistence, the knowledge and the sheer guts to sail thousands of miles into the unknown ocean until he found land.

Columbus was born at the crossroads between the Middle Ages and the Renaissance and showed the qualities of both eras. He had the firm religious faith, the a priori reasoning and the close communion with the Unseen typical of the early Christian centuries, yet he had the scientific curiosity, the zest for life, the feeling for beauty and the striving for novelty that we associate with the advancement of learning.

In 1482 Columbus tried to sell his idea of reaching the Indies to Portugal, then the liveliest and most progressive country in Europe and the center for exploration and discovery. Portugal had discovered the seven islands of the Azores (one third of the way to America) and had colonized the Cape Verde Islands off Africa. The Portuguese were not interested in Columbus' proposals as the "dark continent" was there particular interest.

On May Day 1486 Columbus landed in Spain and for six years tried to convince King Ferdinand and Queen Isabella of his enterprise and had to sustain a continual battle against sheer indifference.

On April 30, 1492 contracts between Columbus and the Sovereigns of Spain were signed and sealed. Columbus was promised the titles of Admiral of the Ocean Sea, Viceroy and Governor of all lands that he may discover. Moreover, Columbus would receive ten per cent of all gold, gems, spices or other merchandise produced or obtained by trade within a discovered domain. He would have the titles and emoluments for himself and heirs and successors forever.

August 2, 1492 was the deadline that Ferdinand and Isabella had given all the Jews in Spain to either embrace Christianity or be executed if they did not leave Spain. As Columbus was preparing to depart on August 2, 1492 thousands of refugees on crowded ships were bound for the more tolerant lands of Islam, or for the only Christian country, the Netherlands, which would receive them. If there had been a new prophet among the Spanish Jews he might have pointed out the Columbus fleet to his wretched compatriots on that August morning and said "Behold the ships that in due time will carry the children of Israel to the ends of the earth."

Columbus would make four voyages to America. He would die in disgrace with a deep sense of injustice at not receiving his full share of the discovered wealth and in ignorance of the magnitude of his accomplishments.

In 1492 celestial navigation was in its infancy and only rough estimates of latitude could be made from the North Star. Columbus relied on "dead reckoning" by which the course and position on a chart is plotted from the elements of direction, time and distance. Columbus obtained his directions from compasses (circular cards graduated 32 points N, N by E, NNE and so on with a lodestone under the north point). Time was measured by half-hour glasses. Distance was the greatest variable as the navigators had to estimate the speed of the vessels. It has been determined that Columbus made an average 9 percent overestimate of his distance by placing the islands of his discovery further west than they really were.

On October 12, 1492 at 2 a.m. Rodrigo de Triana, a lookout on the Pinta, one of the three vessels of the first voyage, sighted land and by noon Columbus landed on a small island in the Bahamas which he named San Salvador — Holy Savior.

The natives of the island, the Taino branch of the Arawak called "Indians" by Columbus, indicated by sign language that scores of islands lay to the west and south. The natives led Columbus by their usual canoe route to a large island called Colba (Cuba) which Columbus

decided was the Chinese province of Mangi.

On January 4, 1493 Columbus started the homeward passage and on March 15, 1493 the Nina reached her home port followed shortly by the Pinta. The Santa Maria had been wrecked on a reef near the present Cape Haitien, in the Republic of Haiti. Columbus brought back native captives of the Taino tribes. Almost the entire Taino race was exterminated within half a century. It may be said that the Tainos had their revenge on Europeans through the present as they innocently brought to Spain in their bloodstream spirochoeta pallida, the spirillum of syphilis.

Columbus' assertation that he had indeed reached the Indies was accepted at its face value by the Spanish sovereigns and the Pope but other navigators claimed that Columbus could not have reached Asia.

On Columbus' Second Voyage (Sept. 25, 1493-June 11, 1496) Jamaica, Nevis, St. Kitts, Puerto Rico, the Virgin Islands and other islands were discovered.

On The Third Voyage, (May 30 — August 31, 1498) it is believed that Europeans first set foot on the American continent when Columbus and some of his sailors landed on the Paria Peninsula of Venezuela. Columbus was now convinced that he had discovered an unknown continent which he called Otro Mundo (other world) and wrote in his journal that this continent was Terrestrial Paradise, the Garden of Eden.

Columbus' fourth and last voyage to America is in many respects the most interesting (May 9, 1502 — November 7, 1504). Columbus' main object in this voyage was to find a strait between Cuba (which he still assumed to be China) and the continent that he had discovered in 1498. On December 23, 1503 Columbus' fleet put in at the present harbor of Cristobal, Panama Canal Zone, and stayed there during New Year 1503. Here, had he only known it, Columbus was within a few miles of solving the riddle of the strait. Columbus was within 12 miles of the Pacific Ocean and missed the most important geographical discovery that he could have made on his last voyage.

On May 20, 1506 in a humble dwelling at Valladolid, Spain, at the age of 54 Cristoforo Colombo, the Discoverer of America, died.

Columbus had the ill fortune to die at the moment when his discoveries were little valued and his personal fortunes and expectations were at their lowest ebb. It is one of the ironies of history that Christopher Columbus died ignorant of what he had really accomplished.

There was no flaw and no dark side to the most outstanding and essential of all of Cristoforo Colombo's qualities — his seamanship. As a master mariner and navigator Cristoforo Colombo was supreme in his generation.

Edward Pedrero, M.D.
Tampa

Reprinted from The Bulletin of the Hillsborough County Medical Association October 1977.

Dr. Pedrero is Editor of The Bulletin.

Sarasota Awards Conference To Attract Four Leading Scientists

A Nobel laureate and three other scientists of national reputation have been designated as winners of the first Sarasota Medical Awards for Achievement and Excellence. Each will receive a check for $10,000 and present papers at the first Sarasota Medical Awards Conference next April.

The Sarasota Memorial Hospital Foundation announced the following winners: Dr. Paul Berg, Chairman of the Department of Biochemistry at Stanford University Medical Center; Dr. Eugene Braunwald, Professor of Medicine at Harvard Medical School; Dr. Robert A. Good, President and Director of the Sloan-Kettering Cancer Center; and Dr. Rosalyn S. Yalow, Chief of Nuclear Research Services at the Veterans Administration Hospital, Bronx, N.Y.

Dr. Yalow was awarded the 1977 Nobel Prize for her work in radioimmunoassay.

Winners were selected by a panel consisting of representatives of Florida's three medical schools and several Sarasota area physicians, including FMA Secretary Robert E. Windom, M.D.

The Conference is to be held every other year. The program next April 26-29 is expected to attract more than 500 physicians.

Universal Federally Financed Health Care

When universal federally financed health care was first seriously proposed over thirty years ago, it was projected to accomplish many things.

1) It was to make the most sophisticated health care available to all;

2) By placing physicians and hospitals under control, costs were to be regulated;

3) Service quality could be maintained through government administered quality control mechanisms;

4) Physician and hospital distribution could be guaranteed to a point where geography would be no barrier to the best the nation had to offer, and

5) Medical education and research would progress to a point where killer diseases such as cancer and vascular disease would be brought under control and could be treated with predictable results.

Now, over thirty years later, almost every one of the five goals enumerated above has been attempted through one program or another. First, some form of third party health care is available to all but about 10% of Americans. Second, no cost control mechanism including price controls has been able to overcome the impact of technology, labor costs, liability risks, government control, and quality review by accrediting agencies in increasing health care costs. None of the regulatory measures designed to reduce costs has worked. These include fee schedules, price controls, and health systems agencies.

The third goal of quality control attempted through PSRO has produced little in measurable results. Maybe time will prove politically imposed quality review effective but the results to date promise little.

The main governmental accomplishment in the thirty years comes in the area of hospital distribution. Hill-Burton funds in hundreds of millions of dollars built hospitals all across this land. Following the lead, investor owned hospitals came along and outdid Hill-Burton. Now we have Public Law 93-641 in an attempt to reverse the building trend through local Health Systems Agencies. Physician distribution has been only modestly influenced by government programs although significant constitutionally questionable legislation has been introduced in the area.

The campaign for research and education to eradicate common killer diseases has been modest and faltering. The Regional Medical Programs brought little measurable change in these disease statistics. Direct National Institute of Health grants produced some significant products. The work from this source goes on at a slower pace as purse strings tighten.

This brief review of government efforts in health care outside of public health and preventive medicine reveals that almost all of the goals sought by National Health Insurance have been sought by multiple means; there is little to suggest that a single coordinated program would have done any better.

With the recognition of the aforesaid facts and the obvious impossible to bear inflationar effects of a tens of billions of dollars federal health program, the President met with National Health Insurance chief proponent Senator Edward Kennedy. From that meeting came a sharp change in the Senator's position. The joint statement suggested a major role for the private insurance sector in National Health Insurance and a three year time table. Of the other goals of thirty years ago, little is mentioned except a vague reference to health cost containment.

This country is fortunate that grandiose plans are tempered with conservative judgment. Success of Messrs. Murray, Wagner, and Dingall, sponsors of Socialized Medicine in the 40's, might have spelled health disaster in the 70's, given the present state of the U.S. economy. Let us hope cool heads will prevail in deciding what health government attempts to buy in 1981 if money will buy anything in 1981.

Richard S. Hodes, M.D.
Tampa

Reprinted from The President's Page of The Bulletin of the Hillsborough County Medical Association, May 1978.

Every good idea needs examples more than advocates.

MEETINGS

Approved by the FMA Committee on Continuing Medical Education

SEPTEMBER

South East Pediatric Educational Conference of Florida, Sept. 2-4, Cape Eleuthera, Bahamas. For information: Gerald T. Kilpatrick, M.D., 531 U.S. Highway #1, North Palm Beach, Florida 33408.

Ventricular Performance and Myocardial Imaging, Sept. 8-9, Langford Hotel, Winter Park. For information: Albert M. Ziffer, M.D., 701 Semoran Blvd. #114, Altamonte Springs, Florida 32701.

Transient Ischemic Attacks: The Computerized EEG, Sept. 11, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 West Highland Boulevard, Inverness 32650.

Fifth Annual Cardiovascular Symposium, Sept. 14-15, Hilton Inn, Gainesville. For information: Howard W. Ramsey, M.D., P. O. Box 13494, Gainesville 32604.

Anesthesiology Review and Update, Sept. 15-17, Sonesta Beach Hotel, Key Biscayne. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Sexual Medicine, Sept. 18, Sheraton Riverhouse Hotel, Miami. For information: Domeena C. Renshaw, M.D., 2160 South 1st Ave., Maywood, Illinois 60153.

Clinical Family Planning for Physicians, Sept. 18-19, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Problems in Clinical Cardiology, Sept. 20-22, Miami. For information: CME Office, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, Florida 33140.

Pneumoccal Pneumonia and Polysaccharide Vaccines, Sept. 21, Pan American Hospital, Miami. For information: Hilario Anido, M.D., 5959 Northwest 7th Street, Miami, Florida 33126.

Laparoscopy Course, Sept. 25-26, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Clinical Immunology for the Practicing Physician, Sept. 29-30, The Casino, Pensacola Beach. For information: Douglas Collins, M.D., 1000 West Moreno Street, Pensacola, Florida 32501.

OCTOBER

Current Concepts in Neurology, Oct. 12-14, Doral Country Club, Miami. For information: Allan Herskowitz, M.D., 155 Northwest 167th St., North Miami Beach 33169.

Fourth Annual Pan American Seminar, Oct. 16-20, Miami. For information: CME Office, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, Florida 33140.

Post-Graduate Seminar on Occupational Medicine (in Spanish), Oct. 16-20, Key Biscayne Hotel, Miami.*

Obstetrics and Gynecology Review Course, Oct. 21-Nov. 1, Royal Biscayne Beach Hotel and Racquet Club, Key Biscayne.*

10th Inter-American Conference on Toxicology and Occupational Medicine, Oct. 22-25, Key Biscayne Hotel, Miami.*

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*For information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

Laparoscopy Course, Oct. 25-26, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

NOVEMBER

Thromboembolism and Thrombolytic Therapy, How-When-and Why, Nov. 2, Mount Sinai Medical Center, Miami Beach. For information: CME Office, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, Florida 33140.

Medicine in Maturity (Geriatric Medicine), Nov. 8-12, Don CeSar Hotel, St. Petersburg Beach. For information: American Medical Women's Association, 1740 Broadway, New York, New York 10019.

Current Topics in Perinatology, Nov. 11-18, Caribbean Cruise.*

Adolescent Medicine, Nov. 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Clinical Family Planning for Physicians, Nov. 13-14, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Laparoscopy Course, Nov. 13-14, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Florida Endocrine Society's Fall Meeting, Nov. 18-19, The Colony Beach & Tennis Resort, Sarasota. For information: Yank D. Coble Jr., M.D., 2700 Riverside Avenue, Jacksonville 32205.

DECEMBER

7th Annual Refresher Course for Nurse Anesthetists, Dec. 1-3, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Glaucoma Symposium, Dec. 7-9, University of South Florida Medical Center, Tampa. For information: W. E. Layden, M.D., P.O. Box 21, MDC, University of South Florida, Tampa 33612.

Cardiac Symptoms and Arrhythmias — Their Diagnosis and Treatment, Dec. 8-10, Americana of Bal Harbour, Miami. For information: IMEC, 64 Inverness Drive East, Englewood Colorado 80110.

Coronary Disease, Exercise Testing, and Cardiac Rehabilitation, Dec. 8-10, Konover Hotel, Miami. For information: IMEC, 64 Inverness Drive East, Englewood, Colorado 80110.

Laparoscopy Course, Dec. 11-12, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

1979

FEBRUARY

Second Symposium on Neurological Surgery of the Ear, Feb. 3-8, Sarasota. For information: Ms. Susan G. Brown, 1845 Hillview Street, Sarasota 33579.

6th Annual Pediatric Dermatology Seminar, Feb. 17-25, M/V Buccaneer, Galapagos Islands. For information: Guinter Kahn, M.D. 16800 Northwest 2nd Avenue, Suite 401, North Miami Beach, Florida 33169.

Management of the Tiny Baby — 1979, Feb. 22-23, Dutch Inn, Lake Buena Vista. For information: Keith S. Kanarek, M.D., 1416 South Orange Avenue, Orlando, Florida 32806.

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONERS

GENERAL PRACTITIONER: For well equipped medical clinic immediately adjacent to 120 bed skilled nursing facility; would also act as medical director for nursing home. Salary 100% of intake. Contact: Administrator, Wakulla Manor Nursing Home, P.O. Box 508, Crawfordville, Florida 32327. Phone: (904) 926-7181.

GENERAL PRACTITIONER OR INTERNIST: Excellent opportunity, assume long established practice with a multispecialty group. Present associate leaving the area. Florida license required. Please submit Curriculum Vitae to John F. Kerwick, Hollywood Clinics, P.A., Box 2308, Hollywood, Florida 33022. Phone: (305) 923-4646.

FAMILY PRACTITIONER, for planned rural outpatient clinic to serve East Pasco County, Florida. Will supervise small medical staff. Send curriculum vitae to P.O. Box 1035, Dade City, Florida 33525. An Equal Opportunity Employer.

CENTRAL FLORIDA MULTISPECIALTY CLINIC HAS OPENING for fourth general practitioner. Congenial group; good financial opportunity; new well equipped office near hospitals. Reply to C-888, P.O. Box 2411, Jacksonville, Florida 32203.

FORT MYERS: TWO (2) FAMILY OR GENERAL PRACTITIONERS for independent practice; group potential; minimum 2½ years commitment; hospital; specialty support. Excellent potential income; financing negotiable. Inquire: Dr. P. Callahan, P.O. Box 1686, Largo, Florida 33540. Phone: (813) 446-3245.

SPECIALISTS

CARDIOLOGIST — Immediate opening for Cardiologist or Internist with special interest in cardiology in a semi-rural central Florida community. 135-bed community hospital building new 12-bed CCU. Four family practice physicians practicing quality medicine will provide modern office and guarantee starting salary. Liberal fringe benefits including profit sharing, professional liability insurance, etc. Please reply to: C-887, P.O. Box 2411, Jacksonville, Florida 32203.

CARDIOLOGIST AND FAMILY PRACTITIONER. Immediate openings, private solo practices. Free rent first year in professional building immediately adjacent to hospital. Florida living at its best. Contact Claude Weeks, Executive Director, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

PEDIATRIC RESIDENCY — Unexpected vacancy for PL-1 in a 3 year fully approved pediatric program. If interested, please contact: Keith S. Kanarek, M.D., Director of Pediatric Education, Orlando Regional Medical Center, 1416 South Orange Avenue, Orlando, Florida 32806.

HEMATOLOGIST-ONCOLOGIST for town in Southwest Florida. Write C-885, P.O. Box 2411, Jacksonville, Florida 32203.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

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Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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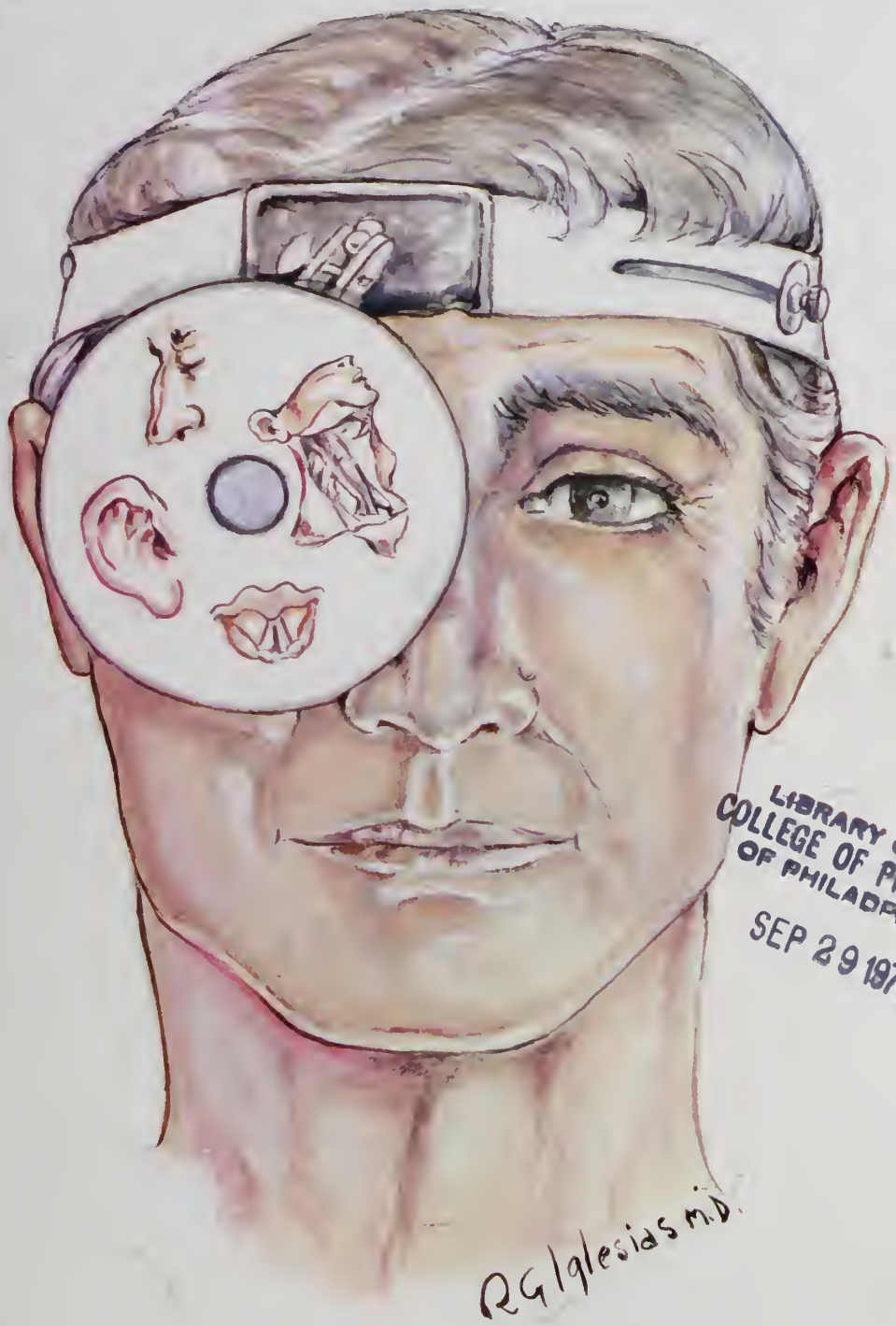
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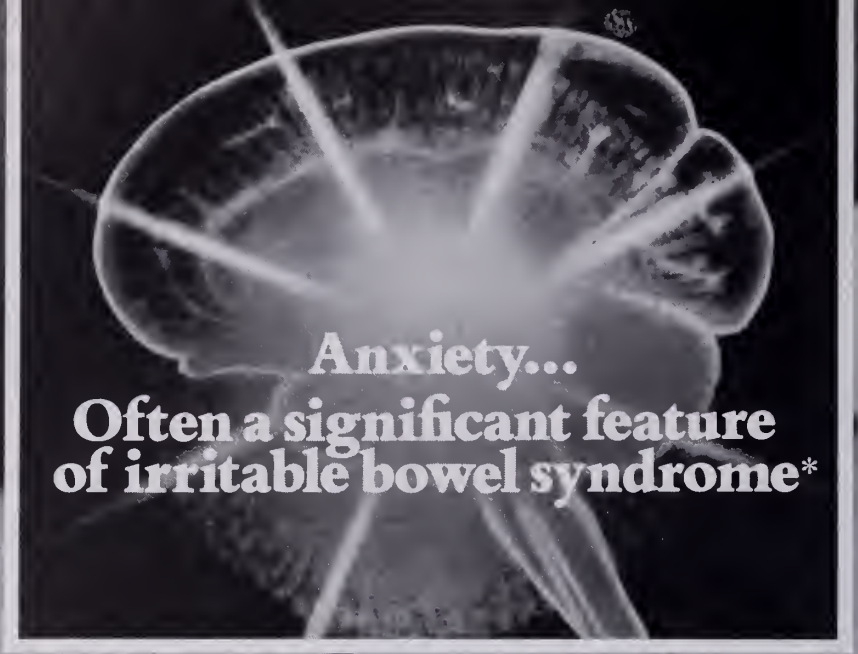


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Special Issue on Otolaryngology

Troy H. Hutchinson, II, M.D.

Guest Editor



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Final classification of the less-than-effective indications requires further investigation.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

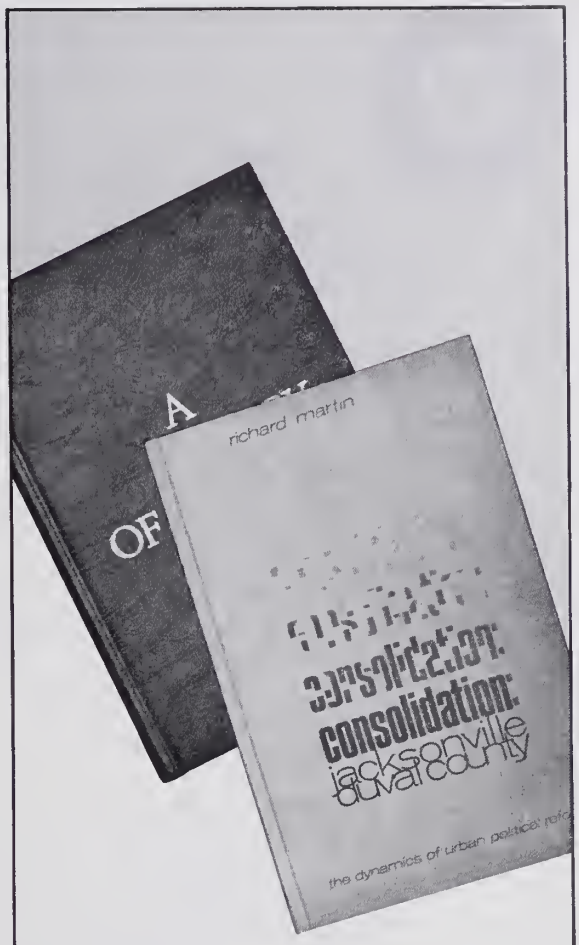
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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This Issue

We are indebted to Dr. Troy H. Hutchinson, Guest Editor of this issue and to the Florida Society of Otolaryngologists for bringing this special issue on Otolaryngology to our readers. We are also most grateful to all of the authors who contributed to this issue of The Journal.

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SEPTEMBER COVER — This month's cover is by Dr. Robert G. Iglesias, a wellknown medical illustrator whose work has appeared in the FMA Journal on many occasions. He is a Fellow of the American Academy of Ophthalmology and Otolaryngology and the American College of Surgeons. He is a graduate of the University of Havana and practices medicine in Tampa.

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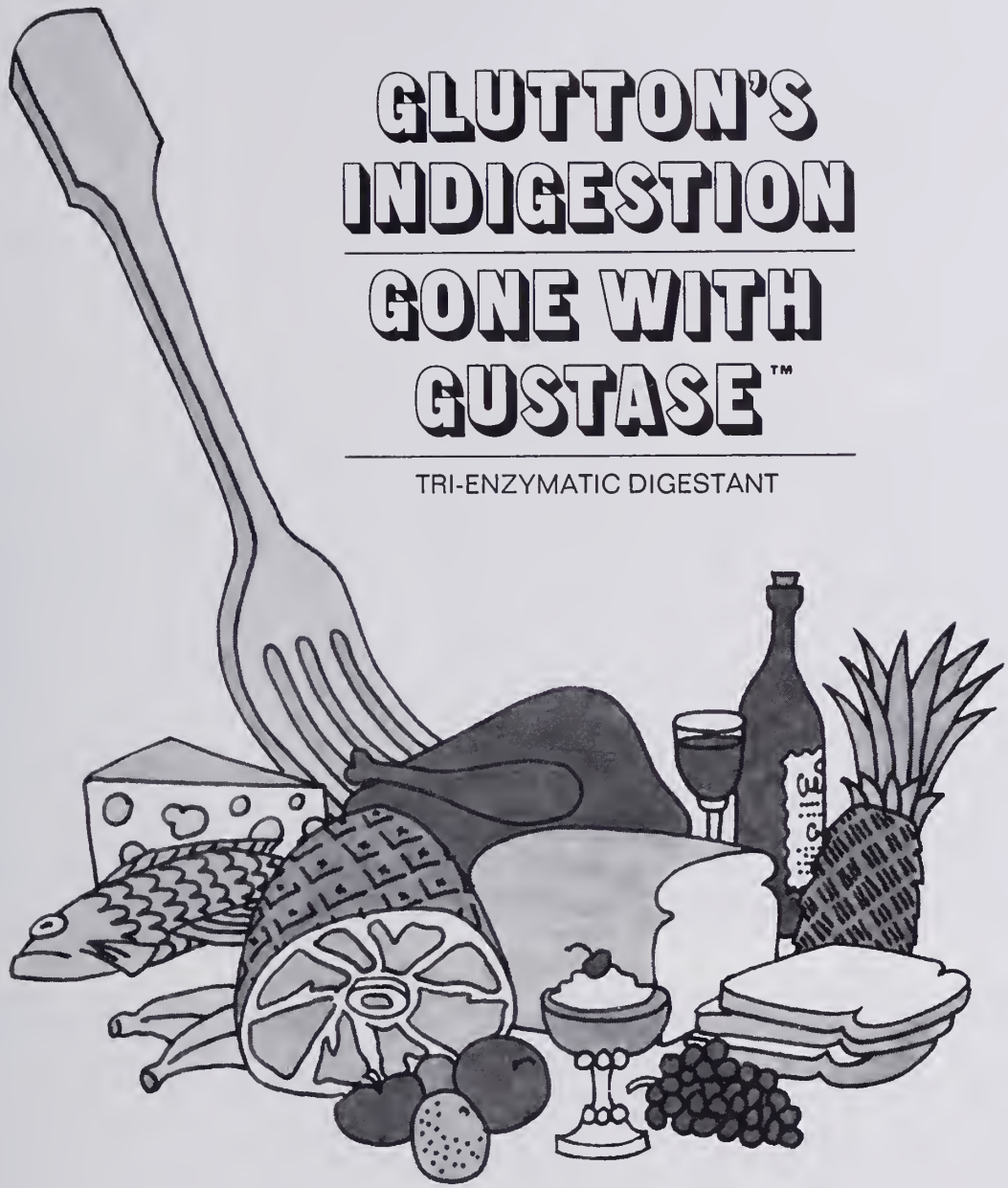
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Robert A. Good, M.D., Ph.D.
President and Director
Sloan-Kettering Institute for Cancer Research
New York, New York

"Molecular Cloning of Genetic Elements: Implications for Basic and Medical Science"



Paul Berg, Ph.D.
Professor of Biochemistry
Stanford University Medical Center
Stanford, California

"Ischemic Myocardial Failure: Its Mechanism, Treatment and Prevention"



Eugene Braunwald, M.D.
Professor and Head of the Department of Medicine
Harvard Medical School
Boston, Massachusetts

Panels and Panelists

"The Impact of Radioimmunoassay on Early Diagnosis and Therapy"

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Chairman
Dept. of Medicine
University of Florida
College of Medicine

Eric Reiss, M.D.
Co-Chairman
Dept. of Medicine
University of Miami
School of Medicine

Allen W. Root, M.D.
Associate Chairman and Professor
Dept. of Pediatrics
University of South Florida
College of Medicine

"Immunologic Control of Carcinogenesis and its Future in Therapy"

Henry Gewurz, M.D.
Professor and Chairman
Dept. of Immunology
Rush Medical College
Chicago, Ill.

Roy S. Weiner, M.D.
Associate Professor of Immunology and Medical Microbiology
University of Florida
College of Medicine

Charles G. Zubrod, M.D.
Director
Comprehensive Cancer Center for the State of Florida
University of Miami
School of Medicine

"Is Genetic Surgery (Gene Therapy) a Plausible Approach to the Treatment or Prevention of Genetic Disease?"

Kenneth I. Berns, M.D., Ph.D.
Professor and Chairman
Dept. of Immunology and Medical Microbiology
University of Florida
College of Medicine

Karl H. Muench, M.D.
Professor of Medicine and Biochemistry
Dept. of Medicine
University of Miami
School of Medicine

Thomas A. Tedesco, Ph.D.
Assistant Professor and Director
Genetics Division
Dept. of Pediatrics
University of South Florida
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Children up to 6 years
Two to three 8 oz. glasses per day.

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Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
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Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

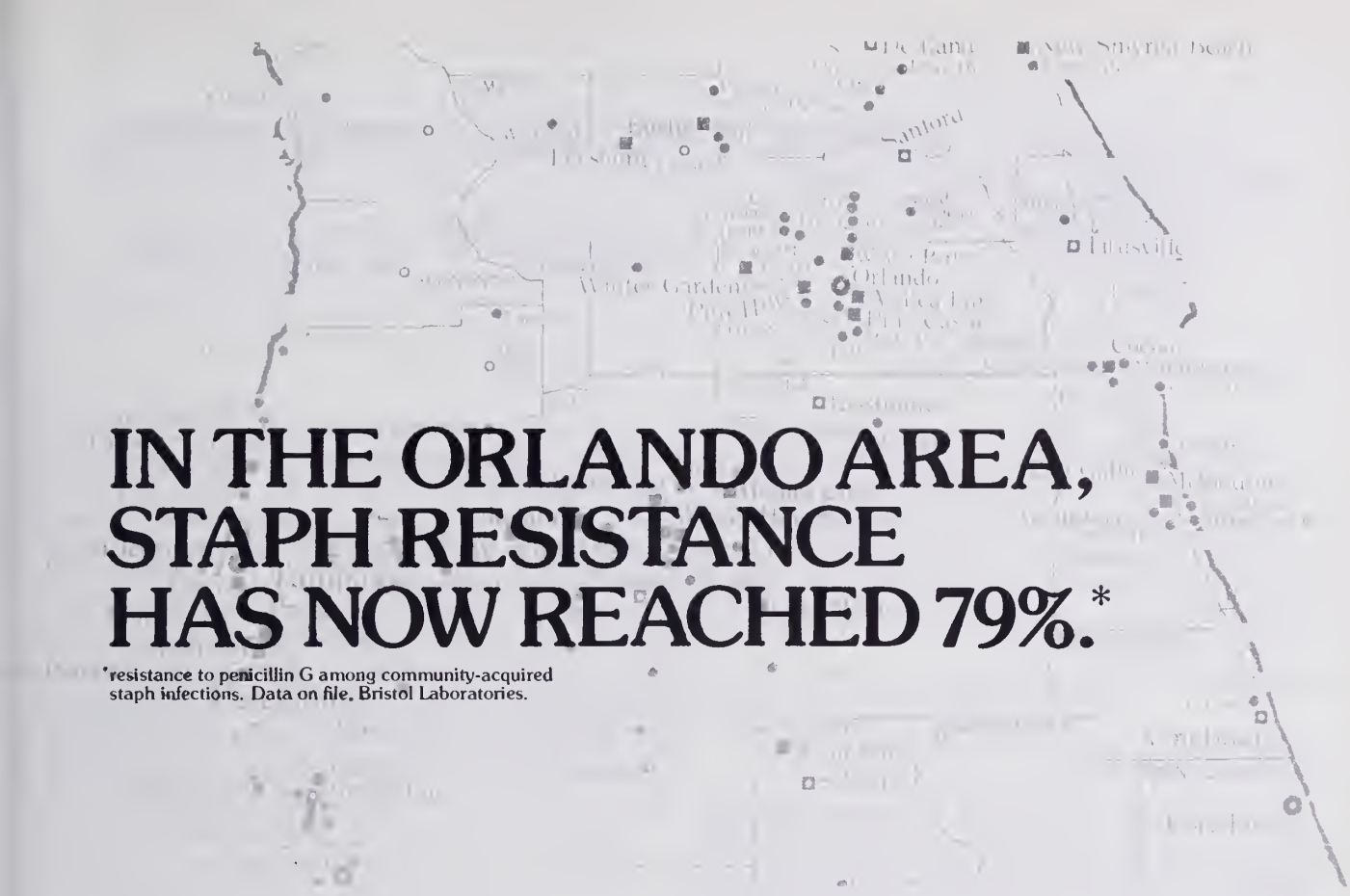
Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

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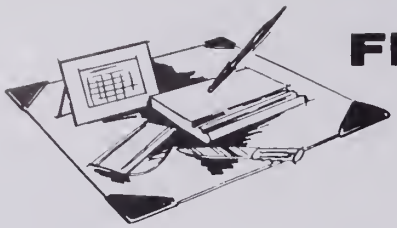
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- 10 times more active against strep than staph.
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‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary for prescribing information.



FROM THE EDITOR'S DESK

COST CONTROL SUCCEEDING

The voluntary effort to control hospital costs is succeeding. Leaders of the program report that for the first four months of this year the annual rate of increase was 12.7% compared with the rise of 15.6% last year. The goal of the voluntary effort—spearheaded by the AMA, the American Hospital Association and the Federation of American Hospitals—is to reduce rate of increase by 2% a year for the next two years.

* * * * *

CARTER REBUFFED

The Carter Administration has received another congressional rebuff in its efforts to shape cost control legislation. The Senate Finance Committee tentatively approved a measure to change Medicare and Medicaid reimbursement of hospitals without including any of the Administration's proposals to broaden the bill. Earlier, the House Commerce Committee stung the administration by removing the threat of federal controls from its bill.

* * * * *

STATEWIDE PSRO

The Texas Medical Association has prevailed in its five-year battle with the Department of HEW to have a statewide PSRO. The Texas Institute for Medical Assessment has been in business since 1973 and is expected to be designated by HEW as the Texas PSRO.

* * * * *

GOVERNMENT MEDICINE

The government's General Accounting Office has given the nation a not-so-flattering view of government medicine. In a report to Congress on the Department of HEW's 112 neighborhood health centers, the GAO said the centers are generally overstaffed, underused and in the wrong locations; and many of the patients have other sources of health care. GAO pointed out that more than half of the centers fall below HEW's minimum standard of 2.7 patients per hour per physician.

HSA BOARDS

Organized medicine has objected to a Department of HEW statement that providers might unfairly influence selection of governing boards of Health Systems Agencies (HSAs). The AMA said the comment was unfair and could contribute to an "unnecessary adversarial relationship between providers and consumers." The AMA statement was contained in a letter calling on the Bureau of Health Planning and Resources Development to revise its proposed rules on the composition of HSA governing bodies. The proposal would require that the consumer majority have members who are "broadly representative" of the socioeconomic and racial groups within the health service area.

* * * * *

HMO EXTENSION

The Senate has approved a three-year $170 million extension of the Health Maintenance Organization (HMO) Program. There was no opposition to a successful move to trim three years and more than $200 million from the extension originally sought by the Administration and to take steps to control door-to-door enrollment of HMO Members.

* * * * *

MEDICARE DISCLOSURE

The Senate Finance Committee has given preliminary approval to a bill that would prohibit the Department of HEW from disclosing the names of physicians and the amounts they receive from Medicare. Meanwhile, a federal judge's decision is still pending on the Florida Medical Association's suit against HEW and Blue Shield of FLorida to enjoin them from making such disclosures.

The Editor



Dean's Page

A Delicate Balance

William B. Deal, M.D.

Recently, the Southern Regional Educational Board published a paper by Eva C. Galambos entitled "Law, Medicine, Veterinary Medicine: Issues in Supply and Demand." This document is a comprehensive review of the expansion efforts made by the South in these three areas in recent years to (1) increase the supply of professionals and (2) broaden the access route to these professions for young men and women.

The facts tell an interesting story. In the last ten years, first year medical school enrollments in the South have increased 74% with five developing schools not included. This has resulted in a 76% increase in the number of Florida residents entering medical school, an increase from four entering students per 100,000 population to five entering students per 100,000 population. With Florida college enrollment increases in the past decade, the number of students entering medical school per 1000 bachelor's degrees decreased from 16.8 to 16.0, opposed to an increase in the South from 16.0 to 16.7 and nationwide, 15.4 to 16.2. Florida's decrease reflects the establishment by the State Legislature of six additional degree granting state universities. Also, this suggests that access to a medical education for Florida graduates has not grown as rapidly as the demand; however, the objective of increasing the supply of physicians has been met.

The physician to population ratio (physicians per 100,000 population) in Florida increased 27% between 1970 and 1976! In the South the ratio increase was 24%, nationally 17%! Clearly, the appeal of the Sun Belt and Sunshine State is evident. However, in 1976 only one state in the South (Maryland) exceeds the national average ratio of 163 physicians to 100,000 population. Florida is very close, however, with 161. Still Florida has physician needs, primarily in rural areas.

Geographic distribution, a common "buzz word" is related to specialty. Non-primary care physicians are generally located in urban areas because of the availability of the necessary support facilities. Primary care physicians are located in both urban and rural areas. Realizing it is more likely that a primary care physician will practice in nonurban areas than non-primary care physicians, emphasis in recent years in medical education has been primary care. This has resulted in an increase in the percent of internists and pediatricians in Florida but the percent of family practitioners has declined slightly; however, the number of family practice and other primary care residency programs has increased. The effect of the expansion of these programs has not been fully appreciated since many are not of sufficient age to have a significant number of graduates.

It appears that Florida has fared well in the absolute increase in the number of physicians in the state. Still a need exists for better distribution. This will be accomplished when the established residency programs in the Central, North Central and Western parts of our state have matured because residents tend to stay in the area where they received their training. Immigration of physicians from other states and the number of residents in training in the state, hopefully in time will correct the maldistribution.

A balance, though, must occur between the need for medical care (and consequently the number of physicians) and the availability of a medical education for our Florida young men and women. This delicate balance is dynamic and should be monitored carefully.

Dr. Deal is Vice President for Health Affairs and Dean, University of Florida College of Medicine, Gainesville.

● Dr. Deal, University of Florida College of Medicine, Gainesville 32610.

NORTH FLORIDA REGIONAL HOSPITAL
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September 14-15, 1978

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Director: Howard W. Ramsey, M.D.
Co-Directors: Luis J. Cintado, M.D.
Thomas D. Bartley, M.D.

This fifth annual symposium is devoted primarily to a review and reappraisal of past and current concepts of diagnosis and treatment of coronary artery disease. A full and exhaustive review of recent data comparing medical and surgical therapy of patients with angina will be presented. Other topics to be discussed include bacterial endocarditis, the myocardiopathies and the current status of cardiac transplants.

A special section of the program, to be presented by Mr. Melvin Belli, will be devoted to an analysis and discussion of current medical-legal problems including the proliferation of malpractice suits.

An outstanding faculty has been assembled for the symposium and the program should be of interest to all physicians involved in the care of patients with cardiovascular problems.

FACULTY

Ralph Alley, M.D.
Christiaan Barnard, M.D.
Melvin Belli, Lawyer
Donald Effler, M.D.
Peter Gazes, M.D.
Goffredo Gensini, M.D.
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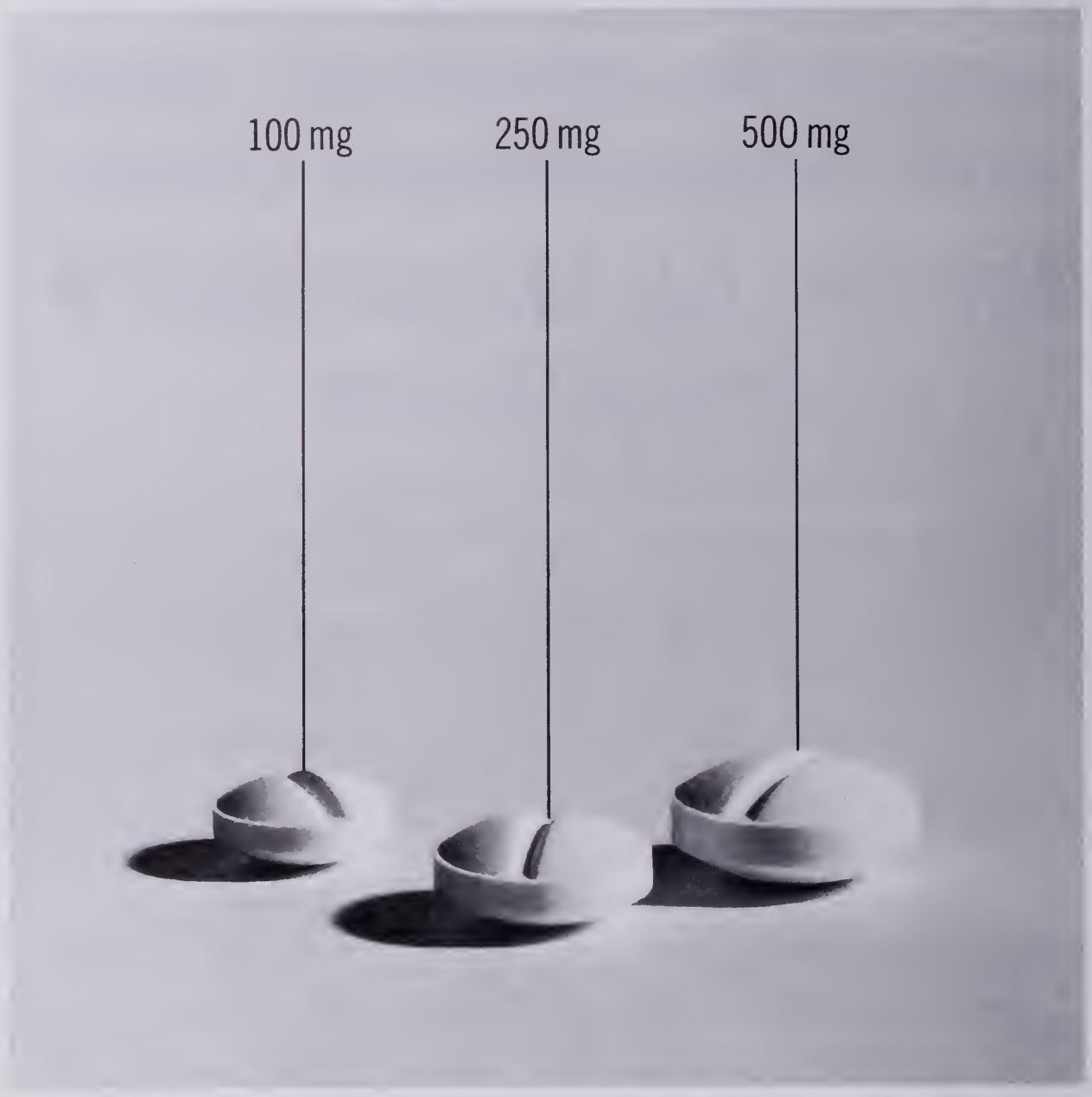
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Special Issue on Otolaryngology
Introduction

Troy H. Hutchinson II, M.D.
Guest Editor

The Florida Society of Otolaryngology is pleased to accept the invitation of the Editors to present this special issue of the Journal of the Florida Medical Association.

From the nadir of our specialty in the 1940's when it was primarily concerned with the treatment of medical problems and surgical treatment was limited to the problems of infectious disease, the scope and capabilities of our specialty have broadened immensely. The advent of antibiotics began to control acute infectious diseases and Otolaryngology turned its attention to other entities of the head and neck area. With his unique knowledge of head and neck anatomy and physiology the Otolaryngologist of that time began developing techniques and expertise in the treatment of cancer, endoscopy, chronic diseases of the ear, restoration of hearing, problems with facial plastic reconstructive surgery, and upper respiratory tract allergy.

The history of Otolaryngology in Florida is well covered in the lead article by Doctor Dekle Taylor, and parallels the growth of ENT in the United States. Otolaryngology today is a regional specialty, providing comprehensive care of problems of the head and neck (exclusive of Ophthalmology and Neurosurgery).

Because of these remarkable advances, the American Board of Otolaryngology (founded in 1924 — the second oldest Board) increased the length and scope of training. Residents are required to serve one or more years in a general surgery residency followed by three years of Otolaryngology training. During these formative years, broad training is provided in the medical aspects of our field, as well as intensive training in Head and Neck, Oncologic, Otologic, and Facial Plastic Surgery.

In our role as comprehensive Head and Neck regional specialists, we work in close cooperation with our colleagues in many related fields.



Dr. Hutchinson

The Author

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We present papers in this issue by members of the Florida Society of Otolaryngology that cover many aspects of our exciting specialty. Doctors Alonso, Cassisi, Chandler, Davis, Karlan and Stubbs cover aspects of head and neck surgery and trauma. Doctors Farrior, Harrison, Pallin, Tyler and Singleton provide insight into modern otology. Problems of facial plastic reconstructive surgery are presented by Doctors Becker, Neel and Simons. Doctor Coleman, et al, have covered the classic problem of sinus disease. Doctors King, Kronman and Schenck present an overview of upper respiratory tract allergy and some aspects of infection.

As guest editor, I express my deep appreciation for the great cooperation received from the authors. My gratitude is extended to members of our Society who have served on the special committee for publication: Doctors Becker, Cassisi, Garlington, Hahn and Simons.



Dr. Garlington

JAMES C. GARLINGTON, M.D.
Doctor Garlington is President of the Florida Society of Otolaryngology and a graduate of Yale University. He is a Fellow of the American Academy of Otolaryngology and an Assistant Professor of Otolaryngology at the University of Florida. He is in private practice in Gainesville and is President of the Alachua County Medical Society.

The difference between men consists, in great measure, in the intelligence of their observation. It is the close observation of little things which is the secret of success in business, in art, in science, and in every pursuit of life.

Samuel Smiles

Otolaryngology in Florida
Past and Present

G. Dekle Taylor, M.D.

Prior to the trend of specialization in the mid 1920's, diseases of the ears, nose and throat were managed by the general physician and surgeon. Otolaryngology is the second oldest (after ophthalmology) surgical specialty in America. The American Board of Otolaryngology was founded in 1924. Specialization soon began in Florida with seven board certified otolaryngologists in 1925. There was a population of 528,542 in Florida in 1900. This expanded to 968,470 in 1920; 2,771,305 in 1950; and 6,789,443 in 1970. Today 283 board certified otolaryngologists together with those noncertified, serve an estimated population of 8,717,334.

During the first four decades of the twentieth century, otolaryngology in Florida was primarily a surgical specialty concerned with the treatment of suppurative diseases of the nasal accessory sinuses and ear, the obstructed nose, diseases of the larynx and pharynx and the management of the obstructed respiratory tract secondary to infection or foreign bodies. Laryngeal surgery was mostly limited to minor endolaryngeal procedures. Cancer surgery, maxillofacial and reconstructive surgery were referred to the general surgeon or sent out of the state to large medical centers. There were no residency programs in the state. Drop ether anesthesia administered in a non-airconditioned operating room with the surgeon using a drop light and a head mirror with a gouge and mallet was the usual routine in the modern hospital until the mid 1940's.

The introduction of prontosil in 1935, sulfanilamide in 1937 and penicillin in 1942 dramatically reduced the incidence of acute mastoiditis and sinusitis and their complications. The specialty of otolaryngology began to undergo many changes. With the diminution of surgery for suppurative disease, diagnostic and therapeutic endoscopy were being shared with the developing specialty of thoracic surgery. The majority of adenotonsillectomies were performed by physicians other than otolaryngologists. Surgical procedures on the paranasal sinuses and turbinates diminished with the better understanding of allergic management and the realization of the limitation of surgery in these diseases. Concern for the future of otolaryngology was felt in the late 1940's.

A new era for conservation of function and restoration of hearing arrived when Dr. Julius Lempert perfected the fenestration operation for the surgical restoration of hearing in otosclerosis. Dr. Lempert also introduced the surgical drill, the headlight and magnification which dramatically changed otologic surgery. Dr. Lempert's greatest contribution was his ability, willingness and enthusiasm to train other otologists throughout the world. The introduction of the operating microscope by Dr. Shambaugh was destined to greatly change surgery in the ear, larynx and sinuses and to be utilized by ophthalmologists, neurosurgeons and vascular surgeons in the future.

Otology flourished following these innovations with the rapid development of stapes mobilization, stapedectomy and tympanoplastic procedures. Improved diagnostic studies have made possible the early diagnosis of acoustic neuromas. Dr. William House developed the translabyrinthine resection of cerebellopontine angle tumors, greatly reducing the morbidity and mortality of these tumors.

In the late 1940's residency quotas in otolaryngology, already few in numbers, were not being filled throughout the United States. There has been a remarkable evolution in otolaryngology since the early 1950's. The greatest impetus has been the vision and effort of men dedicated to the improvement and advancement of the specialty and the establishment of excellent residency programs for the training of physicians in both scientific and clinical otolaryngology. Today Florida otolaryngologists are well trained in head and neck, maxillofacial and reconstructive surgery. They perform middle ear, mastoid and labyrinthine surgery. In addition to three years of basic sciences and clinical otolaryngology, they have served at least one year in

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general surgical training. They are well versed in the medical and allergic management of diseases related to the ears, nose and throat. Fellowships are available for more advanced training in head and neck, maxillofacial, otological and neuro-otological training. In the United States today there are more than 100 approved residencies in otolaryngology, training in excess of 1,000 residents.

The State of Florida now has three excellent residency programs. The University of Miami School of Medicine, Florida's first medical school, accepted its first class of 22 students in September of 1952. A small volunteer faculty, headed by Dr. George B. Lawson, provided teaching in clinical otolaryngology. Otolaryngology began as a division of the Department of Surgery in 1957. Dr. J. Ryan Chandler was chief of the division. The Division of Otolaryngology was made a full department in 1970, and Dr. Chandler now presides as Chairman of this department. Thirty-nine physicians have received their training in otolaryngology. Thirteen reside in Dade County. The remainder are practicing throughout Florida and the United States. One is practicing in Peru.

The University of Florida at Gainesville established the J. Hillis Miller Health Center to train physicians and other health-related specialists to serve the expanding population of Florida and the southeastern United States. The College of Medicine accepted its first students in September of 1956. The Division of Otolaryngology began in July of 1961, with a rotating house staff from the Department of Surgery, under the leadership of Dr. George Singleton. The first residents in otolaryngology were accepted in July of 1962. This institution has trained 32 otolaryngologists, most of whom now practice otolaryngology in the southeastern United States.

Florida's third medical school was initiated by the University of South Florida in Tampa in 1971. Dr. J. Brown Farrior, a gifted surgeon and teacher long active in the dissemination of knowledge, developed a residency program for otolaryngology at Tampa General Hospital 30 years ago. Dr. Louis Clerf was the first inspecting officer for the residency program. This was the first approved residency in otolaryngology in the State of Florida and has been continuously approved for the past 30 years. This department was incorporated in the medical school of South Florida. Thirty-seven otolaryngologists have received their training at the Tampa General Hospital.

Otolaryngology has been greatly enhanced by these excellent training centers where there is an active program in both basic and clinical research. Physicians well-trained in all disciplines of otolaryngology are now available throughout the state providing excellent medical care.

Recognizing the need for graduate education, a group of four ophthalmologists and two otolaryngologists, established the Florida Mid-Winter Seminar of Ophthalmology and Otolaryngology in 1945. Dr. H. Marshall Taylor and Dr. Walter Hotchkiss were the otolaryngological co-founders of this organization which was organized for the advancement of scientific and medical knowledge. Outstanding national and international faculties have provided programs annually for the past 32 years, attracting hundreds of physicians throughout the United States. The Seminar was first affiliated with the graduate school of medicine at the University of Florida and became affiliated with each of the three medical schools in the state as they were established. It now supports research activities in the Departments of Ophthalmology and Otolaryngology at The University of Florida, The University of South Florida and The University of Miami.

The Florida Society of Ophthalmology and Otolaryngology was organized in 1940. In 1966 a diversity in interest and purpose warranted the division of this society into two separate societies. The Florida Society of Otolaryngology, functioning as an educational and socio-economical vehicle, meets bi-monthly. A recent innovation is participation by the residency program of the three state medical schools which has created a fine learning experience and excellent contact for the membership.

A history of otolaryngology would be incomplete without mention of the inter-relations with other disciplines. The advancements of this specialty would not have been possible without the modern hospital and its sophisticated diagnostic and therapeutic services, the excellence of anesthesia, nursing services, audiologists, the pharmaceutical industry and pharmacists, optical and instrument makers, hearing aid manufacturers and numerous other ancillary aids. Otolaryngologists acknowledge the cooperation of medical and surgical colleagues, a symbiosis which allows for the excellence of patient care.

● Dr. Taylor, 221 Marshall Taylor Doctors Building, Jacksonville 32207.

We see things not as they are but as we are.

Tympanoplasty — Indications and Techniques
Myringoplasty, Tympanoplasty and Mastoidectomy

J. Brown Farrior, M.D.

Abstract: This article is to give the general physician understanding of his patient's problem, in regard to chronic perforations of the eardrum and the chronic draining ear. I will begin with a few definitions of myringoplasty, tympanoplasty and mastoidectomy and then proceed to a discussion of each type of perforation of the eardrum, concluding with a discussion of the indications and a brief outline of the types of tympanoplasty and mastoidectomy, including total reconstruction of the ossicular chain and new eardrum.

Tympanoplasty is the rebuilding of the new eardrum and the sound conductive mechanism from the eardrum through the malleus, the incus and the stapes, to conduct the sound waves to the inner ear.

Myringoplasty is a term used for closing a perforation of the tympanic membrane itself and this is classified as a tympanoplasty, Type I. Tympanoplasty's Type II, III, IV and V depend upon the degree of destruction of the ossicular chain and the utilization of the remaining incus (II), the stapes (III), stapes footplate (IV), and/or a window in the horizontal semicircular canal (V).

Chronic disease of the middle ear may destroy all or any part of the ossicular chain. Middle ear disease is frequently associated with chronic disease in the mastoid, so that the patient may require a combined mastoidectomy and tympanoplasty. It is this complex variation of middle ear and mastoid pathology that makes each ear operation an individual challenge.

The object of any type of tympanoplasty is first to seal the middle ear and prevent external reinfection of the middle ear, and secondly where possible to improve the patient's hearing. In tympanoplasty, the chances of obtaining hearing improvement could vary with the location of the disease, the destruction of the ossicles, and the ventilating function of the eustachian tube. The best results are obtained in simple perforations of the eardrum when the malleus, incus and stapes are still present and freely mobile (Fig. 1). The next best results are obtained in perforations of the eardrum where the stapes itself is still present and freely movable. A new eardrum and/or ossicles could be reconstructed on top of the freely movable stapes and thereby reconstruct the conductive ossicular chain. Reconstruction of the ossicular chain is usually accomplished with bone grafts. These grafts may vary from the patient's own incus or malleus head, cortical bone grafts, homograft incus' to a homograft malleus. These bone grafts are drilled with microscopic accuracy so that they interlock to conduct the sound waves to the inner ear, truly micro-orthopedic surgery.

The great joy of 40 years of ear surgery is that no two ears are alike. Ears are more individual than individuals. Each week I continue to encounter some new variation in middle ear pathology.

In **traumatic perforations** of the eardrum the first thing that the physician should NOT do is to prescribe eardrops. Eardrops are contraindicated in traumatic perforations of the eardrum for they will carry infections into the middle ear and set up an otitis media, causing a middle ear infection and delay healing. In a traumatic perforation, an otolaryngologist should be consulted immediately and as soon as possible the perforation should be inspected under the operating microscope. The margins of the perforation should be aligned and some type of patch applied to promote spontaneous healing. The patch may be nonviable material, such as cigarette paper or a viable fascia graft laid on the surface of the drum to form a bridge to encourage spontaneous regrowth of tissue.

A reconstructed myringoplasty which disturbs the remaining normal drum remnants is not indicated in an acute traumatic perforation. The acute traumatic perforation should be encouraged to heal spontaneously with the aid of an internal or external fascia patch or by splinting the edge of the perforation with an artificial eardrum. To repeat, in an acute traumatic perforation, extensive myringoplasty which disturbs normal tissue is not indicated as the primary treatment.

In a contaminated acute traumatic perforation of the eardrum, as may result from water skiing or scuba

From: The Otolaryngology Service, St. Joseph's Hospital and The University of South Florida College of Medicine, Tampa.

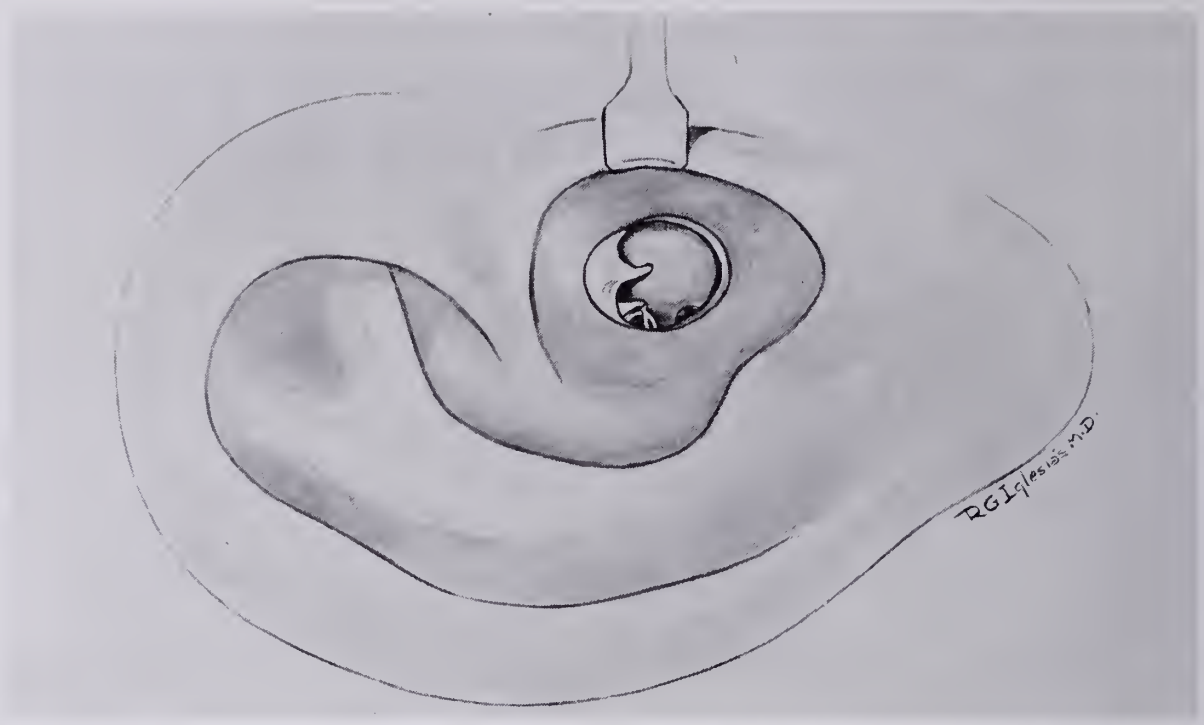


Fig. 1.—The Perforated Eardrum. This large perforation of the eardrum is the type of perforation which is usually caused by a severe childhood infection. Note that just the rim of the eardrum remains, visualized in the surgical position, above is anterior, and to the left is superior. Through the perforation at the lower left are the malleus, the incus and the stapes. A myringoplasty, the reconstruction of a new eardrum, is indicated when the hole in the eardrum is too large to close with office treatment.

diving, the patient should be placed on systemic antibiotics immediately to prevent development of an acute otitis media and the perforation itself treated as described.

When vertigo develops as a result of an acute traumatic perforation, the patient should have an immediate exploratory tympanotomy in search of damage to the stapes, a possible fistula into the inner ear, and/or any dislocation of the ossicular chain. As first aid for an acute traumatic perforation with vertigo, the patient should be kept in the upright or semi-Fowler's position to reduce the cerebro-spinal fluid pressure in the inner ear in an attempt to prevent the development of a permanent fistula and/or a permanent nerve deafness. These cases are rare and in the past they have been treated by watchful waiting. In the future, I feel that otologists will save many of these ears with prompt exploratory tympanotomy and appropriate surgery.

In **welders**, a piece of hot metal will occasionally burn a hole in the eardrum. These slag perforations are an entity unto themselves for the perforation is usually in the bottom and front half of the eardrum where it is almost invisible. These perforations rarely heal spontaneously. I would recommend the previously described do's and don'ts as first aid, but in spite of all efforts, the majority of slag perforations eventually require a formal myringoplasty. Since the slag perforation has burned out the normal vibrating anterior and inferior quadrant of the eardrum it is difficult to restore normal hearing for there will usually be some anterior scarring which limits motion of the drum.

Central perforations of the eardrum (Fig 1) not associated with trauma are usually the result of childhood infections and may or may not be associated with poor eustachian tube function. If your history indicates that there is a recurrent discharge with head colds, then there is usually poor eustachian tube function and/or hypertrophied adenoid tissue. If the ear has been dry for years but has recurrent infection only when water gets into it, then eustachian tube function is probably good and these are the best cases for myringoplasty. If there is persistent discharge from a central perforation this may be the result of a small eustachian tube with

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small external auditory canal.

In a small or stenotic eustachian tube, the mucus from the middle ear and the eustachian tube will tend to keep the ear moist at all times; this is known as a benign mucoid otitis media. In such cases, you can rebuild a satisfactory drum but the hearing will be unchanged or made worse because of the poor eustachian tube function.

In Florida, the combination of a small ear canal and a perforation of the eardrum is a real nuisance for the small ear canal provides poor ventilation of the canal and there is a tendency towards recurring infection in the skin. This in turn reinfects the middle ear and infection of the middle ear tends to reinfect the skin of the canal.

This combined otitis externa and otitis media requires first treatment of the canal infections with a packing saturated with hydrocortisone antibiotic eardrops. By and large, never put drops directly into the middle ear through a perforated eardrum, for this will keep the middle ear continuously infected and will in itself produce what appears to be mucoid otitis media. It is my usual routine to pack the ear canal with six inch strips of one-quarter inch fine mesh gauze and keep this saturated with hydrocortisone antibiotic drops; four drops every six hours. After several days of this treatment, the treatment is changed to a dry dusting powder of simple boric acid and when the ear has been dry for two months, it is a suitable candidate for myringoplasty.

Every physician should be prepared to treat external otitis and protect the middle ear and a perforated eardrum in his office. The packing consists of a six inch strip of one-quarter inch fine mesh gauze saturated with hydrocortisone antibiotic eardrops. In a mixed otitis externa and mucoid otitis media, the canal is gently packed. Packing may be placed gently in the canal and kept moist for two days or more if necessary. In the office, I will usually inflate the middle ear, hopefully with the Valsalva maneuver, then aspirate the mucus with suction and finally insert the moist packing into the cleansed ear canal.

A smaller wick is utilized in the swollen canal of an external otitis. The physician may attempt to dry a mucoid otitis with light dusting of boric acid powder but he should never put drops directly into a large hole in the drum.

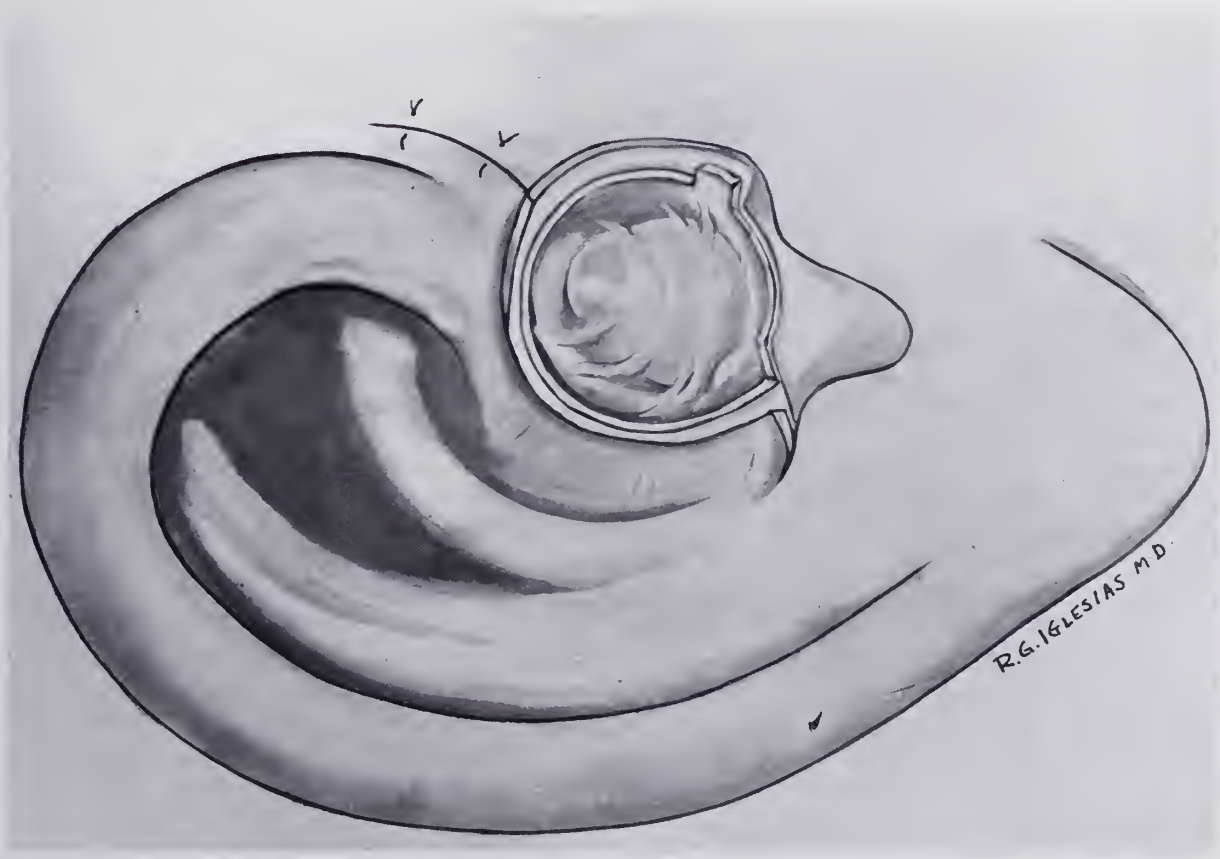


Fig. 2.—The Sandwich Graft Myringoplasty. The tympanoplasty may be performed either through a postauricular incision or through this illustrated endaural incision. In rebuilding the eardrum, the canal skin graft is held in contact with the inner fascia grafts and the entire circumference of the annulus to form the outer layer of this triple decker sandwich graft myringoplasty.

Myringoplasty: In regard to rebuilding the eardrum itself; in the mid-1950's, many surgeons in the country began by patching the eardrum with a vein graft. I utilized external skin grafts, finding that in most instances it was better to rebuild the entire eardrum rather than just attempt to patch a hole. Now almost everyone in this country uses a thick or thin temporal fascia graft as a basic layer for rebuilding the drum. There are many satisfactory variations on this technique with individual surgeons. In my own technique, I use a thin semitransparent temporal fascia graft. The first graft is placed medial to the annulus. This in turn is covered with an outer layer of thin fascia and this in turn is covered with the canal skin (Fig. 2), always reconstructing the vibrating anterior tympanomeatal angle and creating a "triple decker sandwich" graft myringoplasty. Throughout the country with variable techniques, most surgeons now report very satisfactory results in comparable cases with better than 95% closure of perforations.

To return to uncomplicated central perforations of the eardrum of children; because of adenoid and eustachian tube problems, the children tend to have recurrent otitis media with every head cold and they outgrow the tendency at about age eight. In such recurrent childhood infections, a prompt adenoidectomy and then treatment of any associated disease of the nose and nasopharynx is recommended. Usually, I will not recommend a myringoplasty before the age of eight, or at least until the child has had a dry trouble free ear for at least one winter season. The exception to this is a large traumatic perforation which will not respond to treatment.

Attic perforations through the upper part of the eardrum (Shrapnell's membrane) and posterior marginal perforations over the incus and stapes are usually associated with chronic secretory otitis media and poor eustachian tube function. Let me digress for a moment and talk about chronic or recurrent secretory otitis media, a grave problem in pediatric otology. It is the first step in the pathogenesis of the complex cholesteatomas of the middle ear and mastoid. Childhood otitis media should be treated with a complete course of adequate antibiotic therapy for 10-14 days. When the drum does not return to normal and there is a conductive hearing loss, the child should have a general anesthetic with a myringotomy, the aspiration of fluid from the ear, and insertion of a ventilating polyethylene tube. An adenoidectomy is often done to improve the ventilation of the eustachian tube. Although there are academic rumblings about the necessity of adenoidectomy, I hold firm in recommending adenoidectomy in recurrent serous otitis media.

In recurrent serous otitis media, the patient should have repeated myringotomies, aspiration of the fluid or "glue" from the middle ear, and insertion of semi-permanent ventilating polyethylene tubes. The child may require several myringotomies, but if the eardrum can be kept normal until the age of eight or ten, then the child may outgrow his poor eustachian tube function and the myringotomies will have prevented the development of a destructive cholesteatoma.

Of course, in any child or adult with recurrent ear disease, you should always suspect disease of the nasopharynx, such as adenoid tissue, carcinoma, or other forms of tumor. In regard to the conductive hearing loss, every physician should own a tuning fork and do the tuning fork test, the Weber test and the Rinne test. In a unilateral conductive hearing loss, the Weber will lateralize to the involved ear. In the unilateral or bilateral conductive hearing loss, the bone conduction will be louder than the air conduction, particularly when the bone conduction is tested on the upper teeth. This same test holds true for the conductive hearing loss of otosclerosis, the type of conductive hearing loss that is readily amenable to stapes surgery. A 256 Mhz tuning fork is satisfactory, but I prefer the 512 Mhz magnesium tuning fork.

Infected cholesteatoma should be suspected when your patient presents with a foul smelling *persistent* discharge from the ear. The infecting organism is usually Pseudomonas bacillus and sensitivity studies usually reveal that it is resistant to most oral antibiotics. Systemic antibiotic therapy should be used only in control of acute exacerbations of chronic infection and in the control of infection during the pre- and postoperative periods. The infection of the canal can be controlled with appropriate eardrops. Aspiration of the infected debris from the ear canal and cleansing of the infected debris from the cholesteatoma pocket with attic irrigations may temporarily give a dry ear, but surgical removal is the only real treatment of inaccessible slowly progressive destructive cholesteatoma which results from a squamous invasion of the middle ear and mastoid.

Untreated chronic secretory otitis media is the cause of most cholesteatomas seen today. With the reduced pressure in the middle ear, retraction pockets develop in the attic or posterior portion of the eardrum. As these areas become more and more retracted, they tend to accumulate epithelial debris (cholesterin crystals) and when these pockets become infected, they expand rapidly into the middle ear and mastoid. This process destroys the mastoid air cells, the ossicles of the middle ear, and may erode the semicircular canal of the balance system or the fallopian canal of the facial nerve. If these pockets have a wide open mouth, they tend to drain freely and complications are less frequent;

however, if the cholesteatoma pocket develops with a small bottleneck perforation, they are dangerous. This small perforation is usually present in the very top of the eardrum, just above the lateral process of the malleus. It may be difficult to see even under the 16 power operating microscope. If your patient presents with persistent foul discharge, look for cholesteatoma.

Mastoidectomy was thought to be nearly extinct in the first years of antibiotic therapy. A simple mastoidectomy for acute suppurative mastoiditis is rare today. However, with antibiotic therapy smothering the acute infections, a low grade and frequently sterile disease may persist in the middle ear and mastoid to produce the retraction pockets and the invasion of squamous epithelium that lead to the dreaded secondary acquired cholesteatoma. This secondary acquired cholesteatoma rapidly infiltrates the honeycomb of the previously well pneumatized mastoid and extends epithelial roots into the crevices of the cells in and about the labyrinth and inner ear structure.

In the pathogenesis of cholesteatoma, we first see the simple retraction pockets which may be reversible; secondly, the well encapsulated cholesteatoma which is more easily removed; and finally, the invasive cholesteatoma which requires detailed micro-accurate surgery to have a reasonable possibility of complete removal and lasting cure.

The modified radical mastoidectomy and tympanoplasty with removal of the occluding posterior ear canal wall gives better exposure for the microscopic removal of disease from the posterior pockets of the middle ear and the more direct micro-accurate reconstruction of the sound conduction mechanism of the new eardrum. With this more complete surgery, good and lasting results can usually be obtained in a single operation. Many authorities have favored a modified radical mastoidectomy as the operation of choice. Currently, some of those who formerly advocated intact canal wall technique, with staged re-exploration of the middle ear and the mastoid for persistent disease are realizing the advantages of modified radical tympanomastoidectomy.

If the canal wall was left in place in surgery for cholesteatoma, then at least 60% will require repeat operations because of persistent disease. Unfortunately, in children with invasive cholesteatoma the recurrence and reoperative rate is even higher.

The radical mastoidectomy which removes all structures in the middle ear is rarely performed, and its main indication is in a unilateral poor hearing ear with poor eustachian tube function.

Ossicular reconstruction: Any disruption of the ossicular chain, the malleus, incus or stapes, will interrupt the sound conduction between the eardrum and the inner ear resulting in a 40 decibel hearing loss, great enough to require a hearing aid. The ossicular chain may be eroded by squamous epithelium of a retracted eardrum or by a cholesteatoma. In reconstructive surgery of the chronic ear, the most frequent finding is an erosion of the long process of the incus so that although the malleus and incus may move properly, they do not transmit sound to the stapes. In this instance, the body of the incus is removed and drilled to cap the stapes and interlock with the handle of the malleus to re-establish the transmission of sound from the malleus through the incus graft to the stapes and inner ear.

A second most frequent interruption of sound conduction is erosion of the crura of the stapes, with or without erosion of the long process of the incus. When the crura or legs of the stapes have been destroyed, the incus is removed and drilled to form a crutch. This crutch is then replaced with the short process on the protected footplate of the stapes and the notch of the crutch placed under the handle of the malleus so that the movement of the eardrum transmits sound through the malleus to the incus graft, to the footplate of the stapes, and inner ear. There are many variations on these two basic techniques.

If the incus or malleus is not available for a bone graft, I tend to use a cortical bone graft, generally preferring the patient's own tissue. As a second choice, I utilize an incus or malleus homograft from the bone bank. Stainless steel and most plastics are frequently rejected, though porous plastics may be tolerated.

In summary, in tympanoplasty and in combined tympanoplasty and mastoidectomy, adequate exposure is obtained either through an endaural or postauricular incision. A thin fascia graft is removed from the temporal muscle to rebuild the inner and middle layers of the new eardrum. Skin from the patient's own ear canal is then removed to form the outer layer of the new eardrum. All irreversible disease, such as cholesteatoma, is removed with microscopic perfection. In reconstruction, first the sound conduction mechanism with the incus or bone graft is re-assembled, then the inner layer of the eardrum with thin temporal fascia is positioned, and the middle layer of the eardrum is rebuilt with a second layer of thin fascia. Finally, the outer layer of the eardrum with the patient's own canal skin is positioned, creating a "triple decker sandwich" graft myringoplasty.

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Pressure Trauma to the Ears and Hearing Loss

Thomas C. Tyler, M.D., F.A.C.S.

Abstract: Pressure change from flying or diving causes fluid or blood to accumulate in the middle ear, with reversible hearing loss. A more serious complication of inner ear rupture with nerve (permanent) hearing loss can occur. The recognition and distinction between the two types of barotrauma are discussed. Two cases of round window rupture with surgical correction are presented.

Each year many travelers and residents in Florida undergo middle ear pressure changes from flying and/or diving that can lead to hearing loss. This barotrauma is usually self limiting and causes a conductive type hearing loss. Rarely, a more severe form of hearing loss results from pressure change causing a rupture of the round and/or oval window of the middle ear. These structures are the entrance into the cochlea (hearing organ) of the inner ear. If this type of hearing loss is not recognized and treated promptly permanent nerve deafness can occur.

Pathophysiology

The eustachian tube acts as a valve both to allow air to enter the middle ear, and to keep out contaminants. The nasopharynx and the middle ear should have the same atmospheric pressure. Individuals with colds, allergies, (swollen nasal tissues), congenital eustachian tube narrowing and obstruction of the nasopharynx (adenoids, polyps or tumors), and those who don't make a conscious effort to equalize the pressure differential, are much more apt to develop a blockage of the eustachian tube with a *descent* while diving under water or flying.

At 1,800 feet the atmospheric pressure is 380 mms of mercury or approximately 4 lbs per square inch. At sea level, the pressure is 760 mms of mercury or approximately 15 lbs per square inch. The differential in descent if the ears are not equalized can exert considerable negative pressure on the middle ear. This is even more accentuated by descending under water. At a depth of 10 feet, the lbs per square inch is 20 p.s.i. or a differential of 5 lbs per square inch. At 30 feet the lbs per square inch is 30 or a differential of 15 p.s.i. Failure to equalize the pressure between the nasopharynx and the ear at any depth below 10 feet can obviously cause significant trauma (Fig. 1).

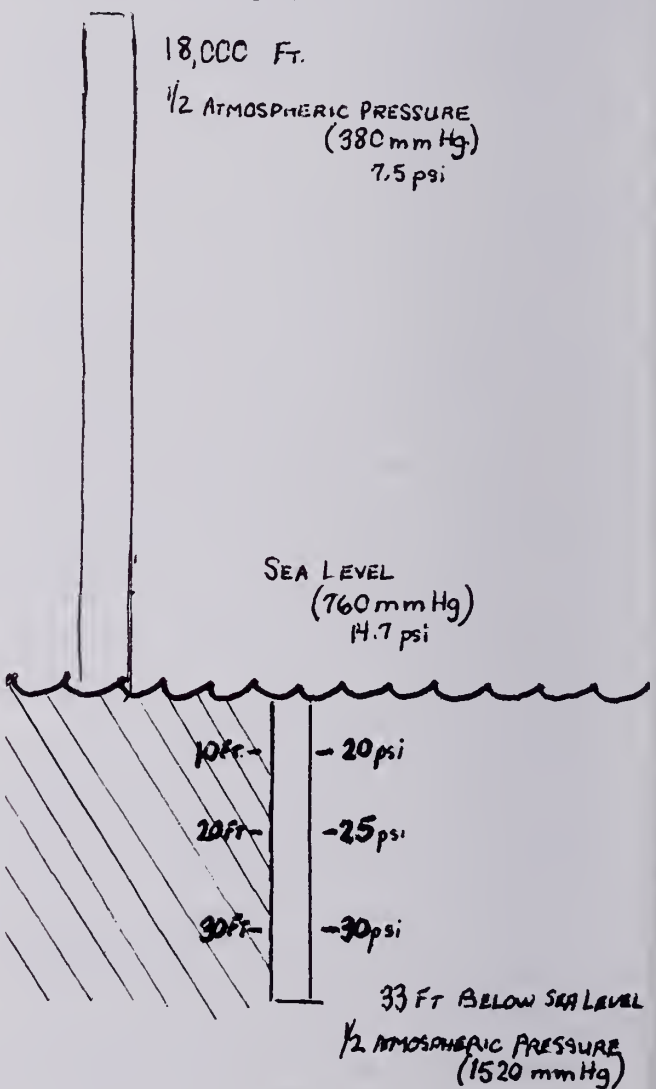


Figure 1.

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A failure to equalize middle ear pressures in descent in the environment causes a negative pressure or suction within the middle ear space. This results in an initial muffled perception and hearing loss because of retraction of the tympanic membrane. Pain results from pulling and stretching of the tissues with an extravasation of serum or blood into the middle ear space. This can lead to imbalance and possible dizziness accompanying the pain and hearing loss.

Types of Hearing Loss

By far the most common type of hearing loss associated with flying and diving is a conductive (reversible) hearing loss. This is caused by serum or blood accumulating in the middle ear in response to negative pressure. A very important type of hearing loss was recognized in the early 1970's which results from a rupture of the oval or round window membrane by the sudden pressure changes brought about by descent in the environment. This results in a fistula from the inner to the middle ear with a loss of inner ear fluids and a sensorineural or permanent hearing loss.

Two mechanisms of trauma cause this problem. The first is an "implosive" phenomena, caused by air rushing into the middle ear and moving the tympanic membrane laterally pulling the stapes from the oval window and pushing in the round window. These sudden forces can rupture either of the delicate membranes (Fig. 2). The second type of sensorineural hearing loss is an "explosive" phenomena. Pressure transmitted via the cerebral spinal fluid and cochlear aqueduct to the ear from a severe increase in venous pressure, as in a valsalva maneuver may rupture the round window membrane.

The diagnosis of barotrauma to the ears is made by a history of pressure change associated with physical findings of a retracted eardrum that is ecchymotic or hemotympanum. A series of very simple maneuvers with a 512 cps tuning fork will localize the hearing problem. The *Difference Test* is performed by striking the 512 cps tuning fork softly on the knee and then comparing the hearing in both ears. The involved ear will have decreased hearing. The *Weber Test* is performed by placing the fork on the upper incisors with the patient's eyes closed. The sound will lateralize to the involved ear if it is the conductive type hearing loss (e.g., fluid, blood in the middle ear) and will lateralize to the better hearing ear if the hearing loss is of a sensorineural or more permanent nature (e.g., inner ear membrane rupture). The *Rinne Test* places the tuning fork, struck very softly, on the back of the mastoid process of the involved ear. The patient with fluid or blood in the middle ear will hear it louder on the bone than when held six to eight inches from the ear (Fig. 3).

The following findings in a patient with a history of diving or flying should alert the physician to the need for an otologic consultation:

1) A significant hearing loss with or without dizziness.

2) A Weber test which lateralizes to the better hearing ear.

Report of Two Cases

Two young men were seen between June 1977 and August 1977 with very similar histories. Both had been diving in approximately 35 feet of water when each experienced an earblock followed by forceful auto-inflation (valsalva maneuver), stuffiness in one ear and hearing loss followed the valsalva maneuver. Both patients were seen within a week of the incident. No dizziness was associated with their hearing loss and examination of the tympanic membranes were normal.

Audiometric tests on both patients showed sensorineural levels at 84 decibels with absent or reduced speech discrimination ability (Figs. 4, 4a, 5, 5a).



Figure 2.

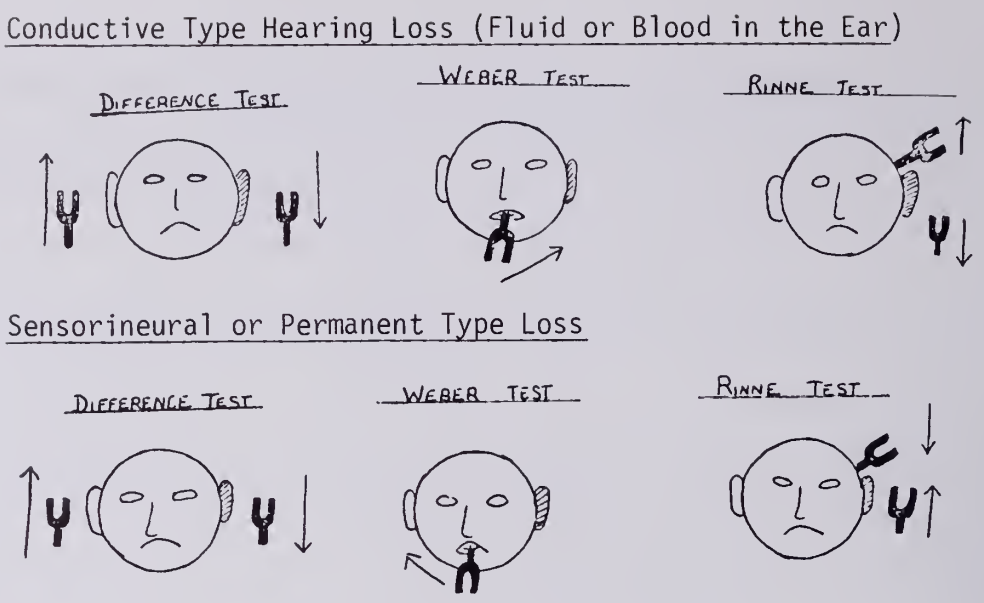


Figure 3.

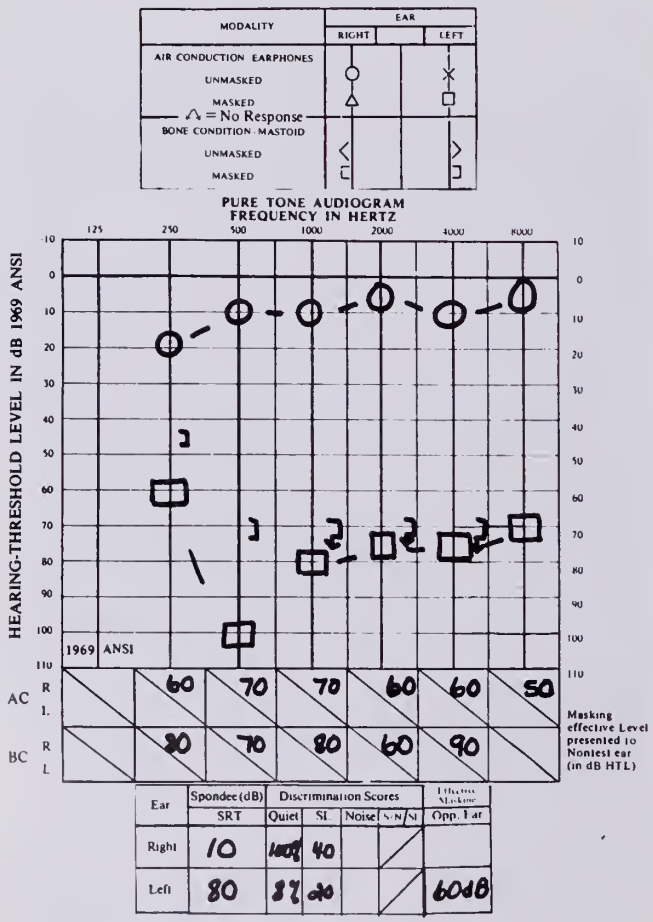


Fig. 4. — Preoperative.

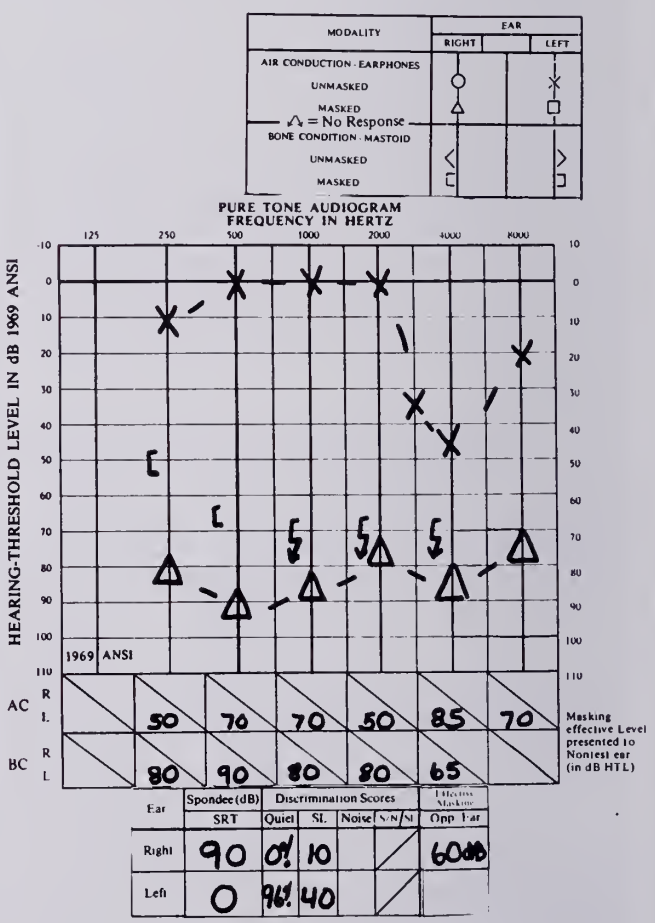


Fig. 4a. — Postoperative.

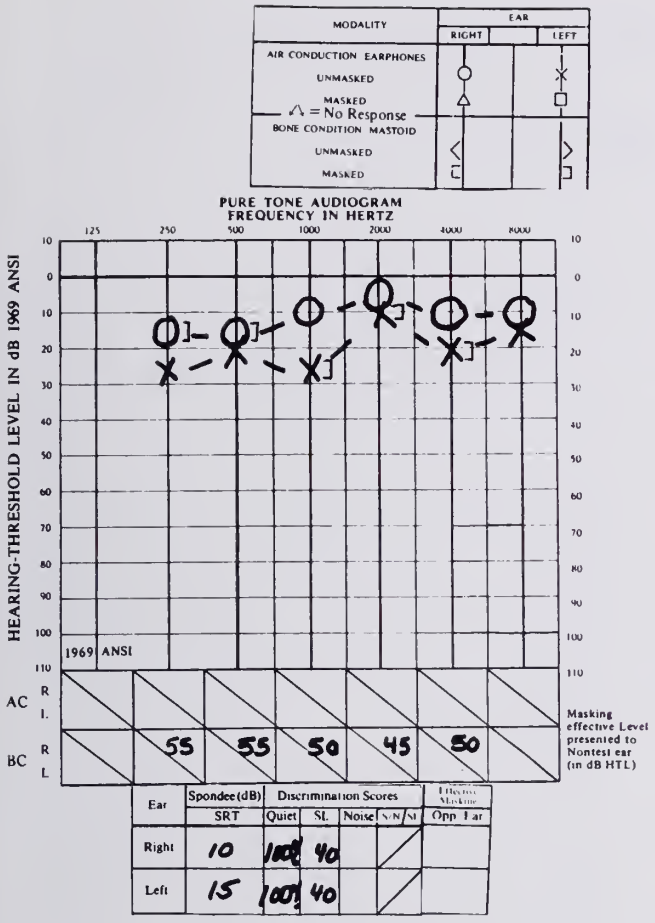


Fig. 5. — Preoperative.

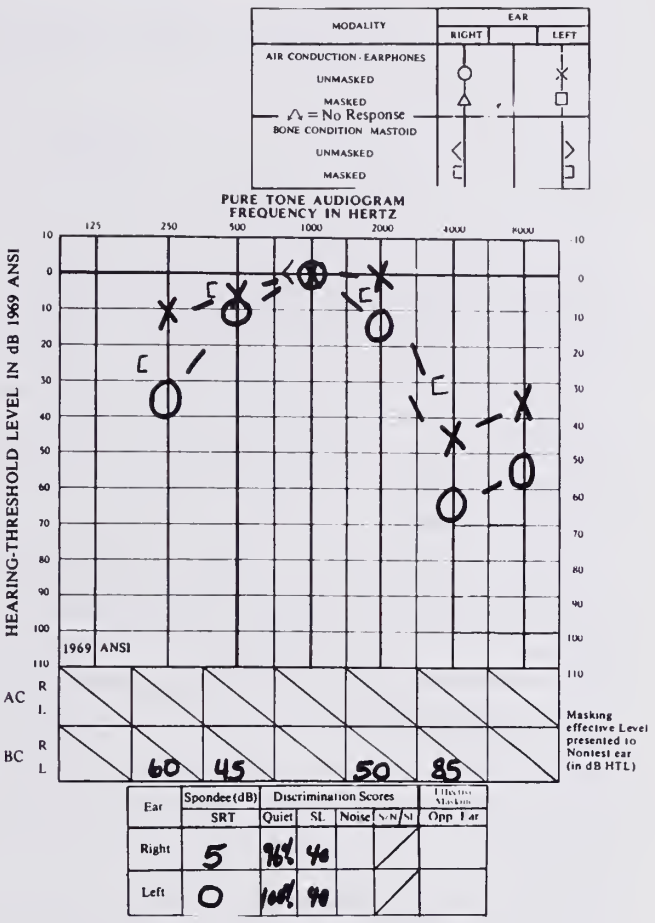


Fig. 5a. — Postoperative.

Discussion of Surgical Findings and Type of Repair

The barotraumatic ear with fluid or blood behind the middle eardrum responds to daily vasoconstriction of the nose and nasopharynx with a nasal spray, antihistamine and decongestent preparation and repeated auto-inflation. The patient should be reassured that his symptoms will subside within 10 days or two weeks and if he is not better, he should be referred to an otologist.

Findings of a sensorineural hearing loss (i.e., the Difference Test showing a hearing loss in the involved ear with the Weber Test lateralizing to the better hearing ear) should alert the physician to the serious nature of this problem. Usually these patients have a very poor understanding of speech whispered into the involved ear. Delay in recognition of the problem and in surgical intervention reduces the chance of full recovery.

In Florida, where so many travelers and sports enthusiasts are diving or flying, the primary care physician should be especially aware of barotrauma middle ear. Most of these problems can very easily be handled by simple medical measures, instructions to the patient and reassurance. The infrequent case which fails to respond to conservative measures and the case which raises the possibility of an inner ear membrane rupture requires otologic consultation. The alert physician may save a very precious quality — hearing.

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A proverb is a short sentence based on long experience.

Cervantes

Dizziness: An Approach to its Evaluation

George T. Singleton, M.D.

The prime objective of the physician treating a patient with dizziness is to identify those cases which require immediate attention and treatment. The second significant step is to clearly identify whether the dizziness is of peripheral, central or systemic origin. Finally, one must control the symptoms while awaiting compensation for a permanent lesion or instituting appropriate medical or surgical treatment for non-emergency situations.

With no other symptom complex is the history so vital as in dizziness. The physician must clearly understand what the patient means by the complaint. Is it turning, spinning, floating, faintness, disequilibrium, an inability to use the lower extremities, a sensation as though one is about to drop off to sleep or is it something else of which the patient complains? It frequently helps to have the patient compare current symptoms to the whirling sensation and disequilibrium that were probably experienced as a child by turning rapidly and suddenly stopping.

In the beginning is the dizziness in attacks or of long duration? Is the recovery rapid or slow over weeks? Does the patient complain of a positional component either initiating the dizziness or making it worse? If there is a positional component, does it require going from a supine to a standing position or is it simply turning over in bed or turning one's head that initiates an attack?

Has the patient had an infection of the ear, a viremia, or venereal disease? Is there a history of trauma from head blow, whiplash, pressure change, loud noise or surgical intervention? Is the dizziness associated with dietary intake or drugs?

Only those points of the physical examination which are particularly important in differentiating between dizziness of peripheral, central or systemic etiology are reviewed. Special studies are limited to those readily available to the primary physician's office. The ears are carefully examined for the presence of an active infection. The only evidence of an attic perforation may be a little crust coming from the area. This may be the only hallmark of a cholesteatoma that may have eroded into the inner ear and caused the dizziness. Hearing in the ear is grossly assessed by use of a 500 cycle tuning fork for comparing air conduction to bone conduction in the patient and comparing the patient's ability to hear the tuning fork to that of the examiner. An idea of the patient's ability to understand spoken language is obtained by blocking the hearing in one ear with the induction of a stream of water from a syringe while double syllable words are presented at normal conversational tones to the uninvolved ear. The use of a watch tick to evaluate hearing is to be avoided as it tests only 4000 hertz, the frequency depressed in all patients exposed to loud noise.

To examine eye movements in the office requires a pair of Frenzel glasses (20 diopter lenses with a light system behind so that the eyes may be observed without fixation). One looks closely for the presence of spontaneous nystagmus in the straight ahead position. Nystagmus on gaze is observed in the four quadrants. Nystagmus on gaze to one side only indicates a very weak spontaneous nystagmus present in that direction.

A caloric test can be done in the office with minimal equipment. All that is required is an emply I.V. bottle to hold water at seven degrees celsius above and below body temperature, a thermometer for checking the water temperature, a bit of I.V. tubing to lead the water from the bottle to the patient's ear, a basin to catch the water, and a stop watch for timing the flow of water. With the bottle about three feet above the head, a sufficient stream of water flows against the eardrum in 40 seconds to give an adequate nystagmus response if one is to be found. The Frenzel glasses should be in place. The nystagmus is timed from the end of the irrigation to the end of the response. The nystagmus is evaluated as to direction, character and magnitude. The response should be equal in the two ears to each temperature of water. A canal paresis is present if the nystagmus is reduced in one ear. Directional preponderance is present if nystagmus is greater in one direction than the other, such as cold water in the left and hot water in the right producing nystagmus to the right greater than the opposite combination for producing nystagmus for the left. At least 20% difference is essential for a significant test.

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Positional testing is done with Frenzel lenses in place. The patient starts in a sitting position looking straight ahead, then is tipped backwards to a supine position and the eyes observed for 15-20 seconds. Nystagmus, if it occurs, is noted for character, direction, duration and latency. If nystagmus does occur, it is observed for at least one minute before assuming that it will stop. The patient is then returned to the original sitting position. The patient is tipped to the right side in exactly the same fashion, and then returned to the upright position. Next comes the left side down and up. Following this, the positions are repeated with the head hanging.

Cervical blood vessels are both palpated and auscultated for bruits and transmitted murmurs. The eye grounds are carefully viewed for the presence of papilledema and for a general assessment of the vessels which mirror those of the central nervous system. Vertebral artery occlusion by cervical arthritis is evaluated by extreme neck torsion. One must be careful not to persist if nystagmus does develop. Impinging the vertebral arteries with arthritic spurs will not only create dizziness but create severe ischemia of the brain stem and lead to more serious problems. Injury to cervical proprioceptors from whiplash is best demonstrated by holding the head still, then turning the patient's body to create the neck torsion. This eliminates any possibility of optokinetic or vestibular nystagmus appearing from moving the head.

A general neurological evaluation is essential and particular emphasis is placed on cerebellar function including a sharpened Romberg (one foot placed directly in front of the other) and walking with the eyes closed.

Postural hypotension is checked by allowing the patient to remain recumbent for 10 minutes to achieve basal pressure before standing. The pressure should be taken immediately upon assuming a standing position. A drop in systolic blood pressure of 30 mm of mercury or greater is significant, and frequently is associated with immediate dizziness.

The Usual Differential Points

There are certain historical and clinical findings that assist the physician in localizing the lesion causing dizziness. Dizziness of peripheral origin creates subjective symptoms far worse than those seen with central lesions. The presence of a hearing loss in association with the dizziness occurs only in peripheral cases or those affecting the eighth nerve. The presence of other neurological defects would pinpoint the lesion centrally. The exception would be the presence of a facial nerve paralysis with a history of trauma which might very well be peripheral rather than central.[1]

Changing direction of spontaneous nystagmus or directional preponderance is fairly typical of peripheral lesions. Positional nystagmus as such occurs with either central or peripheral lesions. The classic nystagmus of benign paroxysmal postural vertigo is readily recognized and occurs only with peripheral lesions. The presence of gaze or spontaneous nystagmus in the vertical plane is indicative of a central lesion in the floor of the fourth ventricle until proven otherwise.

The character of nystagmus, that is, whether it is sawtooth or pendular, helps in localizing the lesion. Sawtooth nystagmus may occur with both central and peripheral lesions but pendular nystagmus occurs only with lesions affecting the peripheral or central visual system. The presence of an unexpected direction of evoked nystagmus, assuming proper positioning, is evidence of a central lesion usually in the region of the vestibular nuclei. Should the nystagmus of the two eyes be different, that is one eye having nystagmus and the other not or the directions be different, then one has evidence of a central lesion in the intranuclear region between the motor nuclei to the eye musculature. Factors which induce an attack after quiescent periods may be of significance in helping localize the lesion. If it occurs from any external or internal pressure change or change in head position, one would suspect the peripheral system.[1]

Peripheral Vestibular Disorders

Benign paroxysmal postural vertigo has a typical nystagmus pattern. When the patient assumes the critical position, head hanging with the involved ear undermost, there is a latent period from two to 10 seconds followed by a rapid crescendo type of rotary nystagmus directed towards the involved ear. The nystagmus slows and disappears. On sitting up the nystagmus appears again with latency but in the reverse direction and of shorter duration. Repeated stimulation significantly or totally fatigues the nystagmus response. The hearing, caloric responses and neurological evaluation are normal.[2]

The above disorder must be distinguished from *perilymphatic fistulas* between the inner and middle ear. To make the diagnosis of a perilymph fistula, one must have a high index of suspicion of every patient who presents with a history of sudden onset of positional vertigo and/or hearing loss, particularly after some sort of traumatic episode. Positional nystagmus occurring in the supine, right ear down and head hanging right positions, was found to occur more often in our series of

fistula patients than in a non-fistula control group. Positional nystagmus usually begins after little or no latency. It is quite long but not terribly severe. Fatigue is slow, if at all. Nystagmus is likely to occur with the involved ear down, though not necessarily beating toward it. Nystagmus rarely reverses direction on sitting up. Even though the fistula test is only positive in one-fourth of our cases, and is reported in only a low percentage of most series, its presence is a strong indication of a fistula. These patients should be clearly identified early and treated vigorously. If treated in the first five days with absolute bed rest and avoidance of increased spinal fluid pressure, most of these patients recover completely without surgical intervention.[3]

Meniere's Disease is perhaps the most frequently thought of malady causing dizziness. To make this diagnosis, one must have at least the following three elements: episodic vertigo lasting from 15 minutes to several hours associated with a decrease in hearing in the involved ear immediately after the attack and an increase in tinnitus. Most cases will also have a full feeling in the ear just prior to the attack and will have a period of deep sleep immediately following the more severe attacks. One in 100 of these patients may have acute drop attacks where they simply fall to the ground without any dizziness whatsoever and no hearing loss. These drop attacks are in addition to the classic attacks of Meniere's Disease.

Infections of the inner ear are a fairly common cause of dizziness. Most cases occur in association with epidemics of viral infections such as mumps and influenza. Viral labyrinthitis usually has associated hearing loss. The patients are prostrate with vertigo for a period of several weeks. Less common today is acute bacterial labyrinthitis that is usually associated with meningitis. Syphilis in its tertiary form is occasionally seen as progressive hearing loss or dizziness or a combination of the two. Syphilis should be kept in mind particularly in patients with a history of having had gonorrhea 15 to 20 years before. The primary lesion of syphilis is not recognized in 30% of males and 60% of the females. With the high incidence of treatment of various respiratory infections with penicillin the VDRL has frequently converted and is negative. The FTA test is the most sensitive for recognizing the presence of tertiary syphilis. The disease can remain active in the inner ear for many years and requires massive doses of penicillin to control. The symptoms are frequently reversible if one adds steroids to the antibiotics.

Trauma to the skull or to the ears directly is likely to cause dizziness. A foreign body pressed into the ear pushing on the drumhead will tend to displace the stapes inward and cause vertigo. Severe pressure changes may as well cause acute vertigo from movement of the drumhead either by pressure or by the accumulation of blood in the middle ear. Obviously a fracture of the temporal bone may go through the inner ear and create severe dizziness and a dead labyrinth.

Central Causes of Dizziness

Vestibular neuronitis is one of the more common central lesions in which an inflammatory response develops in the vestibular portion of the eighth nerve. The patient is acutely dizzy for a period of one to two weeks and has no associated hearing loss or other neurological findings. Neuronitis is thought to follow a viral infection.

Infections including meningitis, brain abscesses, subdural abscesses and the like that develop from the ear or less commonly from the sinuses or blood-borne origin result in severe dizziness as a primary symptom.

Trauma to the brain stem or to the temporal lobe may result in dizziness. Seizures occurring from trauma to the temporal lobe frequently show dizziness, spontaneous nystagmus and occasionally severe directional preponderance. A flat EEG has been reported, as well, as the more common seizure activity.[4]

Multiple sclerosis and other demyelinating diseases frequently affect the vestibular system. These lesions may be in the reticular formation, the medial longitudinal fasciculus or elsewhere. Episodes of dizziness usually last about two weeks. Associated with the dizziness attacks or separately are bouts of decreased vision or problems with visual tracking that are readily recognized on electronystagmography. Generalized degenerative diseases of the entire cerebellum are associated with profound, unrelenting, non-compensating dizziness.

Acoustic neuromas and other *tumors* and cysts of the cerebello-pontine angle normally have dizziness as a prominent feature associated with a disproportionate loss of understandability of spoken voice in relation to the pure tone hearing loss. Early lesions have their findings limited to the auditory and vestibular areas. As lesions grow outside the internal auditory canal they begin to show signs of brain stem compression and involvement of adjacent nerves.

There are a host of *drugs* which affect the vestibular system both centrally and peripherally. The most significant groups are the tranquilizers and sedatives. In addition, one may find dizziness with various medications for arthritis. A number of the more potent diuretics particularly in the presence of renal damage produce vestibular disorders and dizziness. The aminoglycoside and polypeptide groups of antibiotics are ototoxic. A careful drug history and a review of the side effects of the drugs that the patient is on is indicated in every dizziness case.[5]

Localization of central lesions, be they of vascular, tumor, traumatic or infectious origin is aided by electronystagmography (ENG). ENG is a recording of eye movements in the horizontal and vertical planes as the balance system is stimulated by a caloric input, positional change, and pressure change. Visual tracking is recorded as well during smooth pursuit, optokinetic nystagmus, and rapid eye movements (saccades).

The eighth nerve lesions are almost always associated with a hearing loss and are difficult to distinguish from peripheral lesions. One of the most significant differential points is the severe loss of understandability with the nerve lesion. Lesions in the vestibular nuclei may closely mimic those of the nerve; however, vertical nystagmus on gaze and distorted nystagmus that goes in the wrong direction on stimulation are frequent features.

Lesions of the cerebellum, particularly those involving the posterior vermis in the region of the nodulus and the fastigial nuclei, severely affect the vestibular system by knocking out the fine tuning or inhibition of nystagmic response. Patients with lesions in this area are frequently quite dizzy, the nystagmus is longer than usual, the magnitude of the nystagmus is much greater than usual, there is dysrhythmia of the nystagmic pattern, and frequently there are other cerebellar signs and symptoms present.[6]

Lesions of the reticular formation, if small, are difficult to identify. Larger lesions or complete blockage of this area, for instance with barbiturates, result in loss of the slow component for the duration of the nystagmus response.

Rather extensive temporal lobe lesions tend to create an abnormality on EEG, a significant amount of directional preponderance and spontaneous nystagmus. This may occur in seizure form.

Intranuclear lesions between the eye motor nuclei are capable of creating disconjugate movement of the eyes even in the presence of nystagmic response.

Systemic Causes of Vertigo

Cardiovascular problems probably head the list in causing unsteadiness in older adults. This includes all of arrhythmias which produce some ischemia of the brain stem and resulting dizziness as well as lesions of the major vessels ascending to the head. Those with problems in the carotid are readily evident from auscultation for bruits. Lesions of the vertebral arteries are not readily recognized but are frequently brought on by turning of the neck and impinging upon the vessels with arthritic vertebral processes. Generalized arteriosclerosis and minute embolic pheonona also play a role in creating dizziness. One must remember that the arterial system to the inner ear comes from vessels around the brain stem that are terminal arteries. Severe anemia reduces oxygen supply to the brain stem and results in dizziness particularly when the body is required to do heavy work.

There is considerable disagreement relative to the role that *hypoglycemia* plays in causing dizziness. There is a group which feels that hypoglycemia occurs in normal people and that the dizziness that is seen occasionally associated with this is entirely functional. This has not been clearly proved. This probably is as much an overreaction as the individual who orders five and six hour glucose tolerance tests on every patient who is slightly unsteady. Significant hypoglycemia, if present, usually occurs less than two hours after a heavy glucose meal. The significant glucose levels to cause nystagmus are 60 milligrams percent or less. Symptoms can be immediately relieved and the nystagmus will disappear with an oral dose of glucose.

Lesions in the neck such as *cervical arthritis* have already been alluded as causing ischemia of the brain stem. Less well understood is injury to the proprioceptors of the neck from whiplash resulting in nystagmus. To rule out a compression of the vertebral arteries requires careful evaluation of radiographs of the cervical spine and perhaps even vertebral arteriography, although this is rarely required.

A good deal has been written about *thyroid disease* causing vestibular disorders. This is rare in our experience. In no single instance have we seen dizziness from thyroid disease that required diagnosis by special thyroid tests.

Hysteria is occasionally a cause of dizziness and when present is usually recognized by a trained observer. Typically these patients have falling attacks in which they never injure themselves or break anything around them. These patients on examination will walk all over the place with their eyes closed, never really hitting the wall and rarely falling down although they sway severely from side to side. A fall when it occurs is quite a "production." These patients may have what appears at first to be a positive Romberg, then if kept busy with a finger to nose test while performing the Romberg, the instability disappears.

The minimal work up that the primary physician should do on a patient with dizziness includes first and foremost a very careful detailed history with a clear understanding of what the patient means by dizziness. The physical examination should include an evaluation of the eye grounds and search for the presence of spontaneous and/or gaze nystagmus. A check for postural hypotension should be routine. The neurological should include a Romberg and walking with the eyes closed. In addition one should do postural tests

observing the eyes for nystagmic movement behind Frenzel glasses. The hearing should be grossly evaluated by the use of a 500 cycle tuning fork and spoken voice into each ear with opposite ear masked. Caloric tests should be carried out unless a clear diagnosis can be derived without them. Certainly those who have dizziness from a central or peripheral origin without a clearcut diagnosis should have at least minimal calorics carried out with a 40 second irrigation of each ear canal with water, seven degrees Celsius above and below body temperature and the nystagmus pattern observed behind Frenzel lenses and timed. X-rays of the internal auditory canal are routine.

Most patients do not require hospitalization for evaluation for vertiginous attacks. Note that brain scans, EMI scans, multi-laboratory studies, arteriograms, fancy x-rays, and so on are not part of the primary work up of the patient with dizziness.

Obviously patients with life threatening systemic and central causes of nystagmus need appropriate hospitalization and care. Equally significant is the recognition of the patient with sudden onset of dizziness and/or hearing loss associated with trauma. These patients need early clear recognition and diagnosis if they are to recover adequately.

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The thought occurs that perhaps one of the things wrong with our country is success... that there is too much success in it. Success is too easy; in our country, a young man can gain it with no more than a little industry. He can gain it so quickly and easily that he has not had time to learn the humility to handle it with, or even to discover, to realize, that he will need humility.

Perhaps what we need is a dedicated handful of pioneer-martyrs who, between success and humility, are capable of choosing the second one.

William Faulkner

Middle Ear Ventilation Tubes

John L. Pallin, M.D., F.A.C.S.; William H. Behrends Jr., M.A., C.C.C.A. and Linda J. Gilmartin, R.N.

Abstract: A review of the literature and of patient records from The Medical Center Clinic, Pensacola, Florida, has shown that conductive hearing loss due to serous otitis media occurs in a significant number of children. Correction of this hearing loss frequently requires the placement of tympanostomy tubes. Preplacement evaluation and treatment as well as post-placement management and results are discussed.

Verbal skills in the early years of life are dependent on hearing.[1] Hearing loss seriously interferes with this and other learning processes from infancy through the formative years. The effort expended by schools, civic groups, paramedicals and physicians to identify this hearing loss emphasizes the importance of good hearing in the learning years. A large majority of the hearing loss in this age is due to serous otitis media.[2]

Serous otitis media has been observed and reported for hundreds of years. It is most frequently caused by eustachian tube obstruction. When obstruction occurs, air present in the middle ear and mastoid spaces is absorbed by the mucosa resulting in negative middle ear pressure. The pressure may, in a period of one hour, drop as much as 3 to 6.5 cm of water below the ambient pressure.[3] This negative pressure encourages transudation of fluid into the middle ear space. Initially this fluid is of a serous nature but its viscosity increases as it remains in the middle ear space. The resulting irritation and inflammation of the middle ear causes metaplasia and hyperplasia of the mucous membrane creating a secretory effect with additional fluid accumulation.[4] If untreated, this longstanding negative pressure and fluid accumulation can lead to permanent hearing loss and other medical and social complications.

Tympanostomy tubes are often indicated for the treatment of serous otitis media. This was brought to the attention of the medical world by Armstrong in 1954.[5]

A review of patient records at The Medical Center Clinic, Pensacola, Florida, discloses that serous otitis media occurs most commonly between the ages of seven months to five years (Fig. 1). The most common complaint which will bring this child to the physician's office is hearing loss.[6] The loss is usually suspected by a parent or teacher who feels the child is inattentive or uncooperative or identified in a routine screening examination.

Examination of the ear will show the loss or deformity of the light reflex of the tympanic membrane. The tympanic membrane may appear yellow, amber, white or blue. Retraction of the eardrum may create prominence of the short process of the malleus and occasional outlining of the incudostapedial joint. A fluid level or bubbles behind the tympanic membrane may be seen. A necessary diagnostic tool is the pneumatic otoscope to apply alternating positive and negative pressure for the determination of tympanic membrane mobility. This will show the crisp snapping motion of a

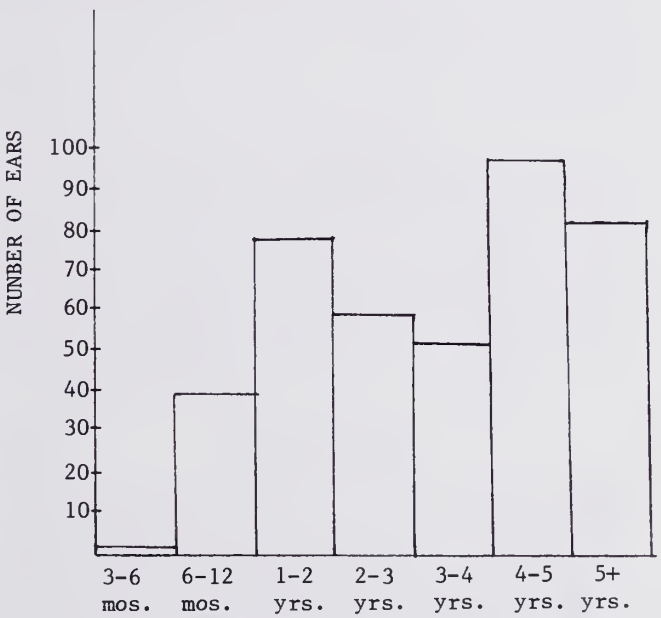


Fig. 1.—Graph representing number of ears from infancy to age five requiring tympanostomy tubes. Of the total 411 ears operated upon, 330 were through age five with 81 being after age five into adulthood.

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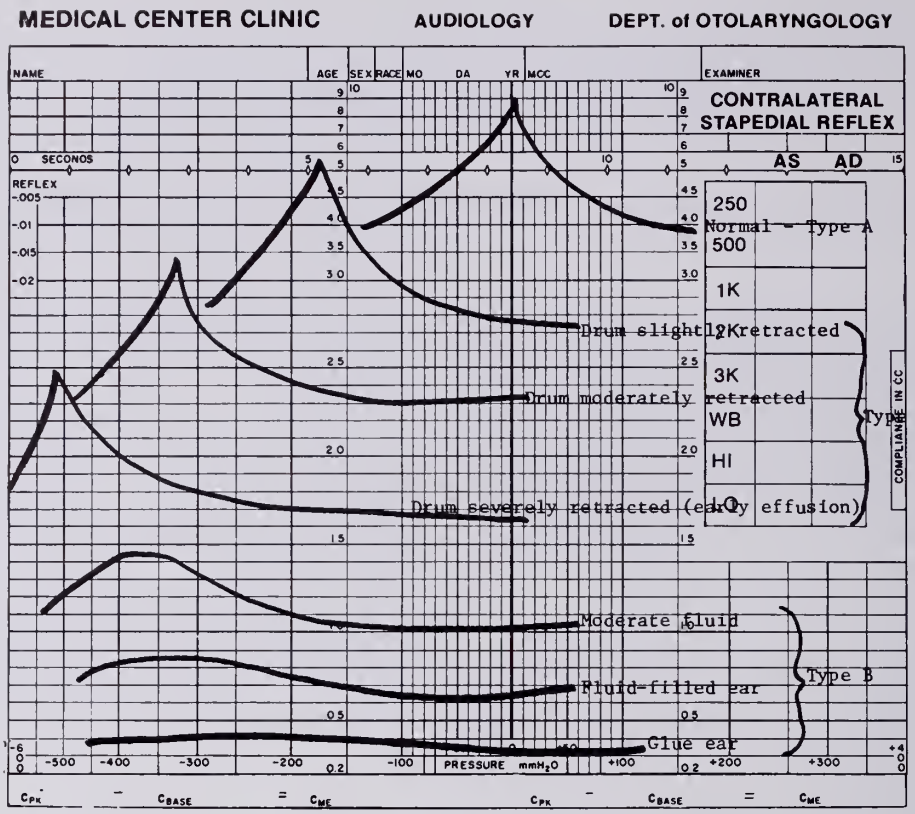
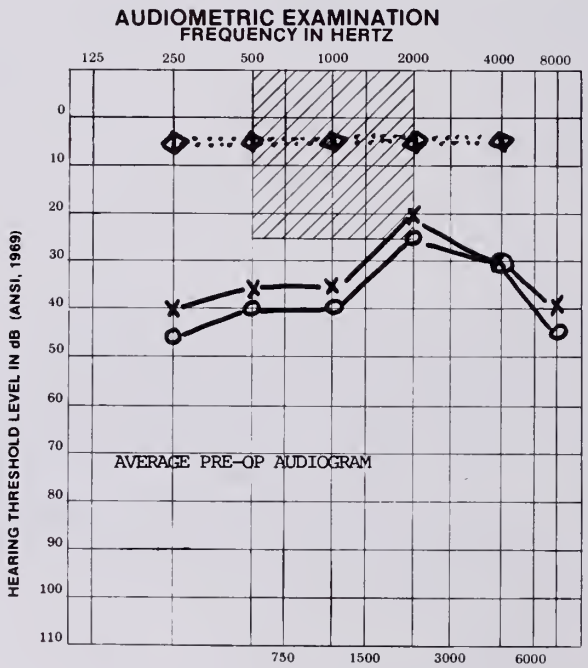


Figure 2



DEPT. OF OTOLARYNGOLOGY

REF. PHYS. _____ DEPT. PHYS. NUMBER 151

NAME _____ SEX _____ AGE _____

CLINIC NUMBER _____ DATE _____

EXAMINER WILLIAM H. BEHRENDS, JR., M.A., C.C.C.

SPEECH AUDIOMETRY

LV/REC		L	MASK EAR LVL	R
LV	SRT	35	-	40
LV	PBQ	100%	-	100%
-	PB LEVEL	75	-	80
	MCL			
	UCL			
	PBN			

EST. ACCURACY good

IMPEDANCE AUDIOMETRY
DONE ☒ YES ☐ NO
AS — AD —

DIAGNOSTIC TESTS

	L	R	FREQ
TONE DECAY			
	- DNT -		
SISI			
	- DNT -		
BEK TYPE	X	X	X
PTA	- CNC -		X

COMMENTS: _____

—ABBREVIATIONS—

DNT - DID NOT TEST
NR OR ↓ - NO RESPONSE
SF - SOUND FIELD
MCL - MOST COMFORTABLE LOUDNESS
UCL - UNCOMFORTABLE LOUDNESS
LV - LIVE VOICE
REC - RECORDED
PTA - PURE TONE AVERAGE
PB - W-22 DISCRIM. LISTS
AC - AIR CONDUCTION
BC - BONE CONDUCTION
CNT - COULD NOT TEST
M - MASKED

Figure 3

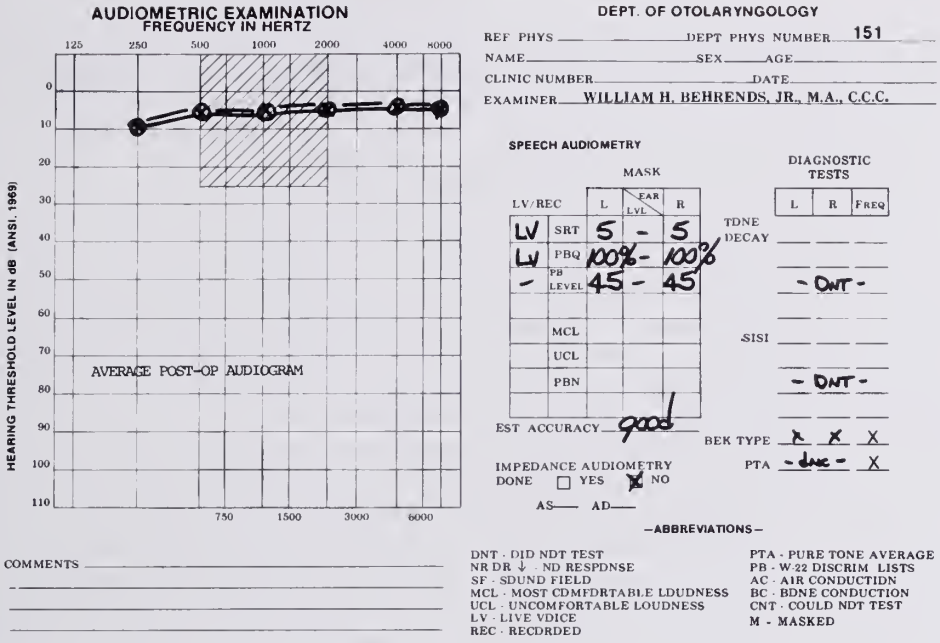


Figure 4

normal translucent tympanic membrane to total immobility due to marked middle ear negative pressure and heavy fluid accumulation. Careful examination of the nose, nasopharynx, oral pharynx and paranasal sinuses will often disclose a cause for eustachian tube obstruction.

Hearing can be tested qualitatively with tuning forks and quantitatively with audiometry. Tympanometry is a new and special audiologic technique for demonstrating negative pressure and fluid in the middle ear space (Fig. 2). It can detect the presence of serous otitis media more accurately than examination of the tympanic membrane.[7] As a result of this accuracy, tympanometry is being utilized as a screening test for serous otitis media. The average conductive hearing loss due to serous otitis media in this group of patients is shown in Figure 3. The correlation of a conductive hearing loss with a type B tympanogram is strong confirmatory evidence for serous otitis media.

The average child with serous otitis media is approached initially with medical treatment. This is currently done by the use of decongestent antihistamine medications, nocturnal humidification and gentle nasal irrigations utilizing a normal saline solution.

When these measures fail, the child is brought to a surgical procedure. A myringotomy is performed with placement of a ventilation tube. When indicated this is accompanied by an adenoidectomy or an adenotonsillectomy.

Following the placement of the tympanostomy tubes the preoperative conductive hearing loss invariably disappears (Fig. 4). Postoperatively the child can lead a normal life including hair washing and swimming with properly fitted earplugs. Instructions are given to the parents to exclude water from the ear to avoid contamination by external bacteria. While wearing the earplugs the child is instructed not to jump, dive or immerse his head deeply under the water.

Because there is no accurate definitive physiologic test of eustachian tube function, tubes are allowed to remain in place one year unless extruded earlier. Approximately 5% of the children required reinsertion of one or both of the tympanostomy tubes. A very small percentage of the children required a surgical closure of a nonhealing tympanic membrane perforation.

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Current Concepts in Hearing Aid Usage

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Abstract: Current concepts of hearing aid usage have rendered obsolete the old rule of thumb that a patient with a sensorineural hypacusis cannot be benefitted by a hearing aid. Recent FDA regulations mandate that a physician's clearance is required before the patient can purchase a hearing aid. The adult hard-of-hearing patient, as well as the hearing impaired child, deserves a detailed evaluation of his communicative disorder, careful selection of the prosthetic device which undergirds his aural rehabilitation and accurate advice regarding the realistic expectations from hearing aid usage. As in many other aspects of his practice, the family practitioner must be familiar with and advise the patient about modern otologic and audiologic rehabilitative procedures.

In the past 25 years, many factors have stimulated interest in the rehabilitation of the hard-of-hearing patient. These factors include the following: the development of refined electro-acoustic instrumentation; modern middle ear surgical procedures; the improvement of hearing aids; the awareness of the effect of certain prenatal conditons on the hearing mechanism; and the growing appreciation by the public of the needs of the hard-of-hearing patient.

The management of the hearing-impaired patient is extensive and could encompass a lengthy discussion. By necessity, however, this paper shall be restricted to current concepts of candidacy for hearing aid usage.

Clinical research and newer electronic developments in hearing aid manufacturing have drastically changed our previous criteria for hearing aid recommendation. The hearing aid industry has effectively adapted the technological advances from communication systems of the space exploration programs to modern hearing aids. Thanks to miniaturization, remote microphones, selective frequency amplification, and other engineering features, patients who could not have been considered hearing aid candidates a few years ago are successfully wearing instruments today.

The hearing aid also is receiving a current regeneration of interest as a relief procedure for the ubiquitous problem of tinnitus aurium. In addition to ear level amplification units for patients with hearing loss, tinnitus maskers (carefully selected noise generators in a hearing aid chassis) are being recommended for persons with normal hearing but incapacitating tinnitus. Tinnitus clinics have been established at certain medical centers in Florida.

In addition to electronic filtering refinements, knowledge of earmold acoustics also allows the frequency response and output of a hearing aid to be modified. Open mold fittings, variable venting systems and tubing with diameter variations enhance certain frequencies while simultaneously altering the peak response of the hearing aid.

Paramount among current concepts is that a sensorineural loss is no longer a contraindication for the successful use of a hearing aid. As a matter of record, thousands of patients with sensorineural hypacusis are now effectively wearing and utilizing hearing aids in their daily lives.

Other significant changes in the criteria for hearing aid candidacy include the degree of loss deemed necessary for successful fitting. For example, it was formerly held that no hearing aid should be fitted unless the better ear had at least a 40 dB loss. Today, the rule is, if a person is experiencing enough difficulty in his communicative situations to present himself to his doctor, he deserves the benefit of a professional hearing aid consultation and trial. The following cases demonstrate that it is now possible to fit persons with mild losses, unilateral losses and high frequency losses, when only a few years ago this was not feasible.

Figure 1. — A 71-year-old male was still active in his own business when he noted difficulty in hearing and understanding some of his customers. A fitting with a conventional type, mild powered, instrument yielded excessive amplification in the low frequencies where his hearing was within normal limits. This amplification created tolerance-problems of loud sounds and much

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discomfort in crowded and noisy environments. A high frequency emphasis hearing aid with sound amplified solely in the 2,000 to 3,000 Hz bandwidth was fitted successfully to the right ear and this was of significant benefit to this gentleman in his day-to-day activities.

Figure 2. — This case was a 50-year-old male physician complaining of deafness of the left ear of many years duration. He reported that he could not ever recall hearing normally in that ear, and cited two incidents which could have some bearing on the loss. A severe case of tonsillitis and adenoiditis at the age of six or seven resulted in an otitis media and draining ear and an acoustic trauma to the left ear caused a severe tinnitus at the age of 10 or 11. He was never able to use the telephone on the left ear and had made allowances for it in numerous social engagements and activities by positioning himself so that his good ear was presented to the person with whom he was speaking. In group discussions, however, the loss of hearing in the left ear presented a significant communicative handicap.

Although this gentleman was a good candidate for an exploratory tympanotomy and possible surgical correction of the significant conductive loss in the left ear, he chose to defer such treatment for the use of a hearing aid. A moderate powered hearing aid with a flat frequency response and a canal-tip earmold was fitted to the left ear. The patient wore the instrument with satisfactory results and was quite pleased with it, particularly when talking to someone on his left side.

Figure 3. — A 55-year-old male presented a high frequency sensorineural loss in the left ear, but his speech discrimination and communicative abilities were essentially within normal limits. The right ear, on the other hand, demonstrated a moderate, sensory (cochlear) hypacusis consistent with advanced Meniere's Disease.

Because his speech discrimination ability was so poor in the right ear (56%) the fitting of a conventional, ear level hearing aid to that ear was precluded. He was,

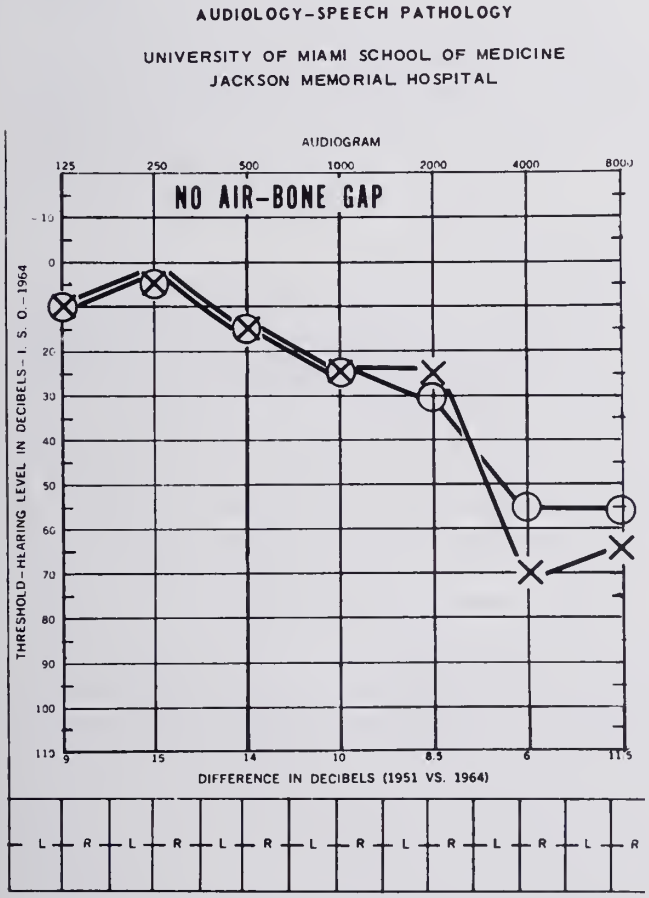


Fig. 1. — Characteristic audiogram of patient with presbycusis who was a good candidate for a high frequency emphasis hearing aid.

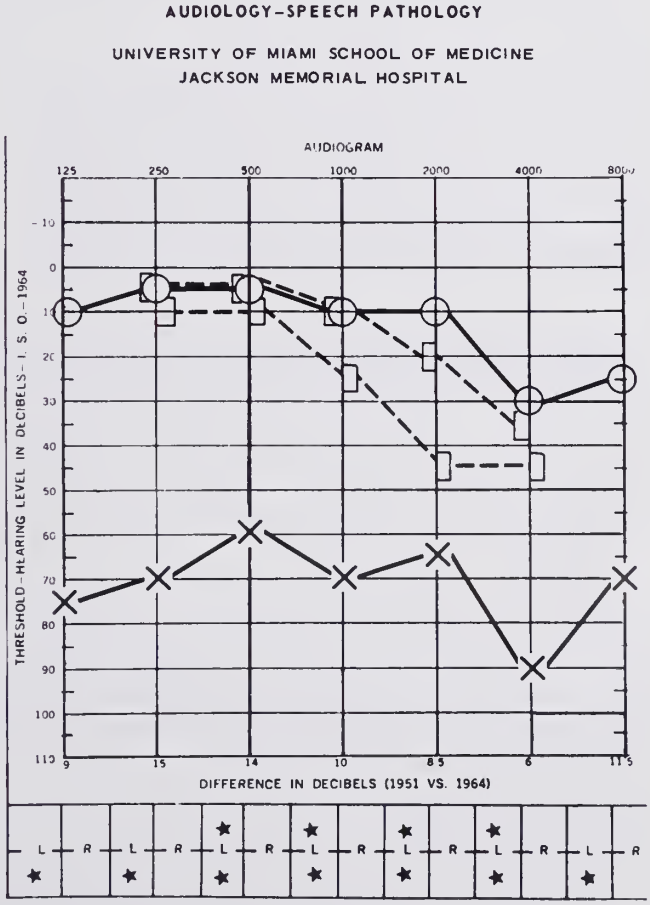


Fig. 2. — Audiogram of patient with suspected ossicular chain discontinuity of left ear who was a good candidate for a unilateral hearing aid fitting.

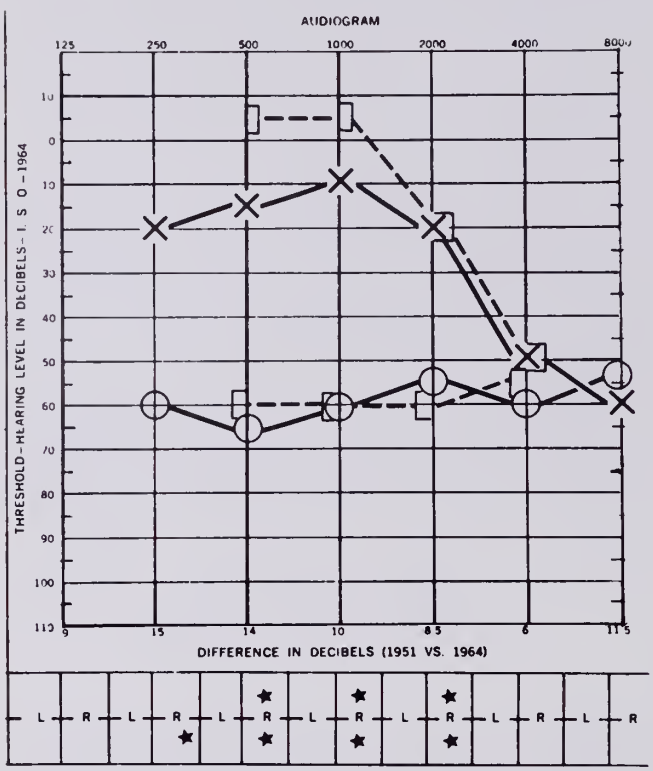


Fig. 3. — Audiogram of patient with advanced Meniere's Disease of right ear who was a candidate for a CROS hearing aid.

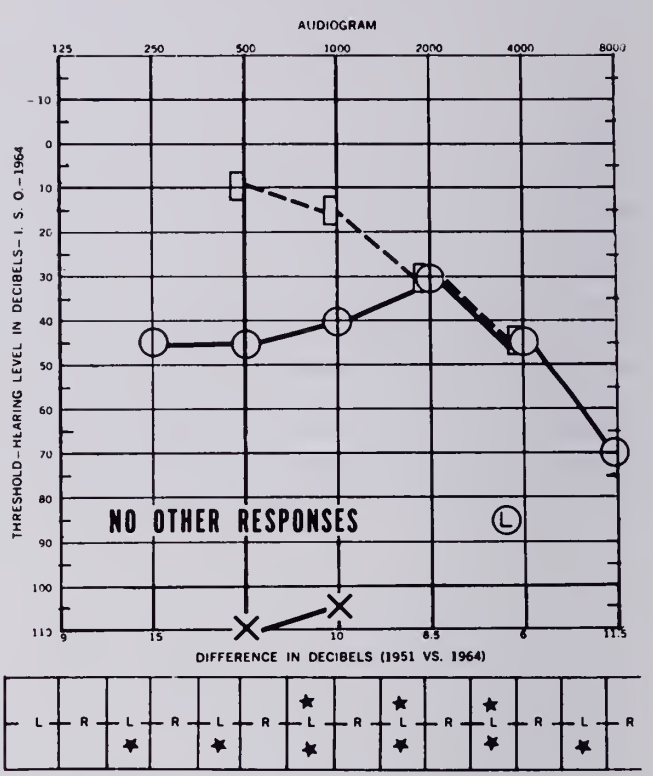


Fig. 4. — Audiogram of patient successfully fitted with a BICROS hearing aid.

however, fitted successfully with an instrument with the microphone on the right side of his head. The amplifier and transducer were placed on the left side and coupled to his better left ear with an open, non-occluding earmold. This type of fitting is a contralateral routing of the signal (CROS) innovation and has been worn very successfully in such instances.[4]

Figure 4.—This 47-year-old female was seen after an unsuccessful stapedectomy procedure on the left ear. The right ear demonstrated a mild, conductive lesion that was fitted successfully with a mild powered, flat response instrument. Because of the continuing communication problems which are inherent with unilateral listeners she was fitted with a second, remote microphone placed on the left ear. This allowed her to pick up speech and sounds which originated from the left side. This particular fitting innovation is designated as a BICROS fitting and has been of benefit to individuals who have no residual hearing on one side, and a loss that is severe enough to be fitted with an ear-level instrument on the other side.

In addition to the technological advances, there also has been an increased awareness on the part of the public that a hearing aid is a prosthetic device and should be selected by a clinical audiologist after clearance from their physician. Moreover, there are a greater number of people today who are preferring to purchase the instrument from a professional source, rather than a merchant. They have more confidence in the quality of care and the advice that they receive from their doctor and their audiologist. This increasing segment of the public desires a freedom of choice of where to buy the hearing aid. They prefer to procure the aid from their doctor or from their audiologist, rather than the commercial hearing aid fitter and seller. An example of this attitude was shown in a 1975 survey taken from patients of the University of Miami Division of Audiology-Speech Pathology. Eighty-six percent of the respondents expressed a preference for a hospital-based hearing aid dispensary rather than a commercial concern.

Similarly, Bailey and his colleagues[1,2] found that 95% of their patients indicated a preference for the

otolaryngology group to dispense hearing aids from their clinic. Consequently, because of these and other surveys, recent years have witnessed an increase in the collaborative involvement of otolaryngologists and audiologists in hearing aid dispensing.[1-3]

Landmark regulations by the Food and Drug Administration concerning the sale of hearing aids went into effect on August 25, 1977. Essentially, the regulations provide that an individual with a hearing loss must have a medical evaluation of his hearing loss by a physician (preferably a physician specializing in diseases of the ear) within six months preceding the purchase of a hearing aid. The physician will provide the patient with a written statement indicating that his or her hearing loss has been medically evaluated and he or she may be considered a hearing aid candidate. This statement implies that the physician has assured the patient that all medically treatable conditions that may affect hearing have been accurately identified and properly treated before the hearing aid is purchased. It should be emphasized that the physician need not prescribe, recommend, or certify that the patient will be helped with a hearing aid.

In the case of children under 18 years of age, the patient also must be referred to an audiologist* for evaluation, hearing aid recommendation, necessary guidance and counselling services, and necessary aural rehabilitation services.

*An audiologist is an individual who has earned at least a Master's degree from an accredited university, satisfactorily completed a Clinical Fellowship Year and passed the examination of the American Board of Examiners of Speech Pathology and Audiology.

An individual may sign a waiver of the medical clearance requirements on the grounds of religious or personal beliefs which preclude consultation with a physician. In this event, the hearing aid seller is required to advise the individual before the purchase that his best interest would be served by having a medical evaluation. The dispenser is prohibited from actively encouraging prospective buyers of a hearing aid to exercise this waiver option.

The 1978 Florida legislative session also was the scene of concerted activity in behalf of the hearing impaired consumer. Consumer-oriented legislators, with the backing and cooperation of otolaryngologists, audiologists, associations for retired persons and parent groups of handicapped children, sponsored, and the Florida legislature enacted, a bill that protects the hearing aid purchaser from flagrant abuses of unethical sales procedures.

These regulations are an attempt to assure the consumer of top-flight medical care by providing appropriate medical clearance and audiological examination before the fitting of a hearing aid.

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The fine art of executive decision consists in not deciding questions that are not now pertinent, in not deciding prematurely, in not making decisions that cannot be made effective, and in not making decisions that others should make.

Chester I. Barnard

The Otolaryngologist and Allergy

Hueston C. King, M.D.

Abstract: In recent years the otolaryngologist has been entering the field of allergy in unprecedented numbers. The reasons for his interest, his methods of approach, his unique position in the field, and anticipated result of his entry are examined.

Daily across the country more otolaryngologists are adding the care of nasal and upper respiratory allergy to their armamentarium of therapy. These are not older practitioners threatened with the loss of surgical activities but young, vigorous physicians at the peak of their ability. Their interest in the field is often developed during residency training, since a working knowledge of allergy care is now a requirement of the American Board of Otolaryngology.

The otolaryngologist has traditionally been a surgeon, and his adoption of this classically medical approach to patient care has somewhat surprised the medical community. The entire field of otolaryngology has been a bit of a surprise, however, since the 1950's when the development of microsurgery of the ear reclaimed the specialty from what seemed certain extinction and in the 1960's launched a rapidly expanding group of young physicians into the medical arena imbued with the regional specialty concept of patient care. In today's complex medical world, no one can be all things to all people. This leaves two choices: one doctrine applied to the total patient as needed, or multiple doctrines applied to a physically limited region. The otolaryngologist has chosen the latter approach and essays to excel in his area. He performs the traditional surgery of the ear, nose and throat as always plus the newer reconstructive microsurgery of the ear and has added head and neck surgery for cancer as well as facial plastic surgery to his repertoire some time ago. He uses his head mirror or headlight on essentially every patient and routinely examines the nose, ears, nasopharynx and larynx. He is generally equipped to follow the condition of the sinuses on a day-to-day basis. Since most otolaryngological allergists confine their work to the upper respiratory area, this equipment and familiarity gives him a unique ability to observe the results of his treatment, adjust therapy as needed and quickly catch and correct complicating problems as they occur. If he must refer his allergy work, he, of necessity, loses contact with the otolaryngological aspects, such as the possibility of intercurrent sinus disease or nasal polyposis. He also loses the opportunity of assaying all aspects of the problem and presenting a combined approach to give what he feels to be an overall superior result.

The public probably would have benefitted had the otolaryngologist become interested in allergy at an earlier date. A conservative figure of the otolaryngologist's problems directly related to allergy would be over 50%. Nasal congestion, sinus disease and obstruction, otitis media, postnasal drip, recurrent laryngitis — these are only a few of the more obvious manifestations. On the more esoteric side, allergic labyrinthitis, intermittent sensorineural hearing loss, eczematoid external otitis and allergic headaches blamed on "sinus" fill the E.N.T. office. With the cost of medical care, the otolaryngologist serves in many cases as a primary care physician. He may prefer referral work but a large number of patients, while they may not know the nature of their problem, do know its location and come directly to the specialist in that area without being screened by a medically-oriented physician. How many sinuses, nasal septums and nasal turbinates have been operated upon needlessly because this was the otolaryngologist's traditional surgical approach, will never be known. How many other allergy-mediated problems have gone by undetected in full view of the examiner, because of his unfamiliarity with the field, presents a poor commentary on the level of acumen of a specialist. Incorporating a knowledge of allergy and applying it appropriately in overall patient care can hardly fail to result in better medicine by the otolaryngologist.

Most otolaryngologists today prefer a method of allergy treatment originated about 20 years ago by several physicians including both otolaryngologists and general allergists. This treatment goes by a variety of names, the most descriptive of which are 'serial dilution

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titration' and 'provocative food testing.' In the interest of brevity, only a synopsis of the approach can be presented here.

Inhalant allergy care: For an allergen to enter the patient, it must enter the body. For practical purposes, this means that it must either be inhaled or ingested orally. Since the otolaryngologist concerns himself primarily with the nasal and upper respiratory area, the majority of his problems will be in the inhalant field. It was demonstrated in the 1870's that it was possible to produce a reaction in an allergic patient by introducing a small amount of the offending substance into his skin, and that, subsequently, relief of symptoms could be obtained by repeated small injections of the allergen into the body. In ensuing years, inhalant allergies, especially those induced by pollens, were treated by this method. The dose of the offending allergen was raised progressively to the largest dose which could be tolerated by the patient in hopes of producing an adequate level of resistance prior to the time that the offending substance would be encountered; i.e., the onset of the pollinating season.

In the 1930's, French Hansel and other otolaryngologists, who were being treated by this method, observed that after a certain dosage level was reached, their symptoms seemed to intensify rather than to improve when the dosage was increased. This led to the concept of treatment by "optimum" dosage as opposed to "maximum tolerated" dosage. It remained for Herbert Rinkel, Russell Williams and Carlton Lee to use this concept in empirically working out a new approach to testing and treatment. The goal was to provide safety in testing, more rapid achievement of maintenance therapy, and a safe, simple method of evaluating any subsequent changes in the patient's sensitivity. The result was the development of Serial Dilution Titration.

The following description of Serial Dilution Titration has been approved by the American Society of Ophthalmological and Otolaryngological Allergy and is on file with CPT-4 and Blue Cross/Blue Shield of Florida. It summarizes the method as concisely as possible:

"A technique of allergy testing designed to improve accuracy in interpreting skin reactions, provide greater safety in testing and treatment and allow for a more rapid arrival at maintenance levels of therapy.

"Used primarily for inhalants, antigens are serially diluted with saline on a 1:5 ratio. Testing is performed by producing a series of identical skin wheals of increasing strength for each antigen, progressing from a non-reactive dilution until a pattern of uniform, increasing reactivity with each wheal emerges. The transition point from non-reactive to reactive wheals indicates a safe level for initiating desensitization, which is performed by subcutaneous injection of gradually increasing doses of the antigen to the point of symptomatic relief. This point is considered the optimum dose and no attempt is made to go above it.

"The method determines antigenic activity of a specific substance to a specific individual, thereby avoiding undesirable reactions from variations in antigen preparation, and allows therapy to be initiated close to the maintenance level, thereby reducing the time needed to obtain symptomatic relief."

Ingestant allergy care: In the treatment of ingestant (food) allergy, most allergists of the non-provocation school treat food allergy by simple elimination of the offending food; identifying it by history, statistical likelihood, or skin tests. The provocation allergist raises two points of practicality: the difficulty of making a rapid, accurate diagnosis of food allergies by the above method and the difficulty of eliminating from the diet multiple foods, especially basic and/or hidden foods, by the active adult. For example, the corn-sensitive patient may not be able to take so much as an aspirin tablet — much less an antihistamine — both of which use cornstarch as a vehicle. Plus, the eating of *any* commercially prepared food is OUT.

For those with disabling asthma or giant urticaria, the elimination route may be undertaken with varying degrees of success. Even here, however, there is a built-in limitation factor in that excessive exposure to a potential allergen tends to produce sensitivity. The allergic patient, eliminating all but a few foods, of necessity, uses these foods to excess and may soon find himself sensitive to them. Most patients with non-disabling nasal and upper respiratory allergies will not even try elimination if more than a very few foods are involved, preferring the disease to the cure. It is for these that provocation allergy has its widest use, providing a compromise between an unacceptable ideal and a practical improvement in symptoms.

The following description of Provocative Food Testing has been approved by the American Society of Ophthalmological and Otolaryngological Allergy and is on file with Blue Cross/Blue Shield of Florida and CPT-4:

"A technique of allergy testing designed to more accurately identify antigenic substances and to provide means of relieving symptoms promptly.

"Used primarily for foods, provocative testing is initiated by deliberately producing an allergic response by giving a substantial dose of the antigen — either by intradermal or subcutaneous injection or ingestion of sublingual drops — then giving progressively smaller doses of the antigen at timed intervals until the allergic reaction disappears. The dose of antigen producing this is termed the "neutralizing dose" and may be used thereafter to combat the undesirable effects of the

offending agent. It is easily apparent that this approach does not differ in principle from serial dilution titration treatment for inhalants, with subsequent establishment of an optimum dose for therapy. In practice, since the effect of an inhalant allergen is apparent in the patient at the time of testing, no further production of symptoms is needed. In foods, the amount of a certain food in the patient's system and the effect it is exerting on his allergy cannot be predicted. Therefore, a mild overdose is given to produce symptoms. This is usually done by the intradermal injection, allowing the physician to study the skin response as well as the symptoms, which do not always match the patient's basic complaints." This, again, presents a compromise between the skin test alone and actual ingestion of the food, with observation of the effects of such ingestion and subsequent neutralization of symptoms by injection of extracts of the food. It should be pointed out, however, that the original provocative food tests were performed by deliberate oral overdosage of the offending food and subsequent neutralization, and that this method is still widely used to clarify questionable diagnosis.

The provocation allergist has now solved one of his practical difficulties: he has provided himself with a means of producing symptoms before his eyes and subsequently neutralizing them. If he cannot do this consistently, throwing in a placebo every so often to be on the safe side, he will not accept the diagnosis. Once he has made his diagnosis, the solution to his second problem is at hand. He has already successfully neutralized the symptoms produced by the offending food. Empirical study over the past 20 years teaches him that repeated injections of the dose of antigen that neutralized the symptoms during testing will allow the patient to eat the food in moderation without ill effect. These injections are usually required once or twice weekly. The decision now returns to the patient as to what to eliminate and what to treat; weighing cost, convenience and practicality with the knowledge that not all neutralization programs are successful and that he may be required to compromise at some point. He has available at least some choice other than living with his symptoms or changing his life-style in a way he cannot (or will not) accept.

These two treatment modalities, serial dilution titration and provocative food testing, represent the stock in trade of the otolaryngological allergist. They are, of course, by no means limited to him. Today a wide variety of specialists have tried the approach with results impressive enough to convert them to the method.

One more aspect of the serial dilution titration approach deserves mention. One of the greatest problems in allergy has been the development of a standard of potency. No yardstick for measuring potency has been truly reliable. This is the reason that most allergists reduce their treatment dose when changing from one batch of vaccine to another. Since titration does not depend on any established yardstick, but only on the reaction of the individual patient, it has been possible to use the method in treating allergies to such commercially unavailable material as volatile oils (gardenia perfume and night jasmine, for example) with encouraging results. Again, this is nothing new. The same principle has been applied to autogenous vaccine for many years by all schools of allergy — only the use is different.

Until very recent years, the immunological basis of allergy was very poorly understood. It is far from entirely clear now. Many of the otolaryngologists' approaches to allergy never have had their effectiveness established other than on a clinical basis; indeed, it would have been impossible to clarify the mode of action until very recently. In recent years, the question of possible placebo effect has been raised over some of the above methodologies of allergy care. This is a bit difficult for the practitioners of this school of allergy to accept, since the results have been so satisfactory for so long. In the long run, however, the raising of such questions may benefit everyone as both the otolaryngologist's methods and the approach used by the general allergist are now being prepared for an exhaustive study using all available means of assaying results.[1] When the studies are complete, everyone's understanding of the field should have improved and it is not unlikely that major changes will appear in all approaches.

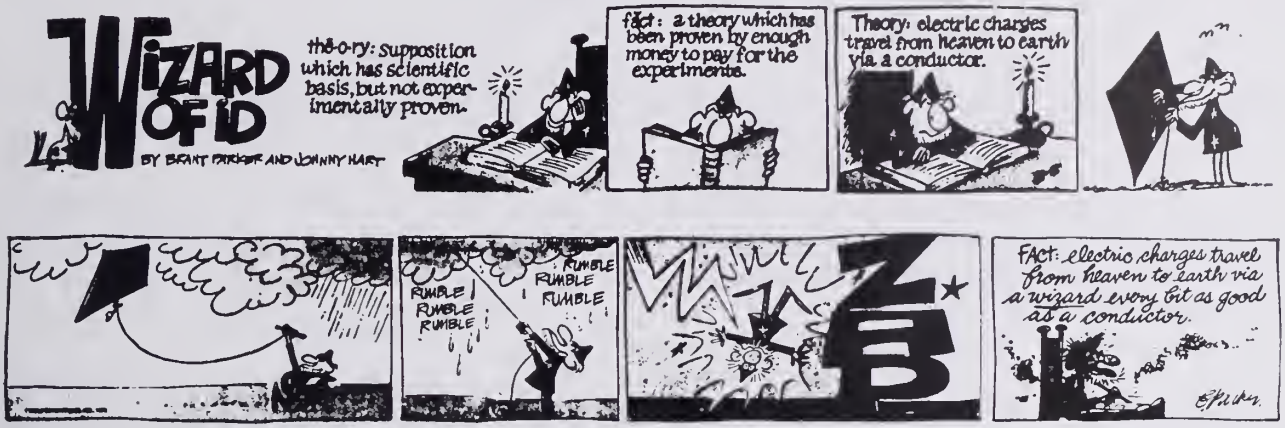
For the present, it is sufficient to note that the otolaryngologist has added a modality of treatment that appears vital to the overall care of other problems in his field. It is to be hoped that his regional approach will benefit his patients heretofore subject to either a group of diverse doctrines administered by a variety of physicians or to surgery alone; and this benefit to the patient is, after all, what medicine is all about.

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1. Two definitive studies on the above approaches to allergy are currenly in preparation; one to be directed and supervised by Dr. Joseph A. Bellanti, Georgetown University Medical Center, Washington, D.C. on serial dilution titration and one to be prepared and supervised by Dr. William T. Kniker of the University of Texas at San Antonio on provocative food testing. Both are expected to run a period of years and utilize all objective determinants available.

● Dr. King, 4675 Ponce de Leon Boulevard, Coral Gables 33146.

The wizard appears to have put the situation in remarkably good perspective.



THE WIZARD OF ID by permission of Johnny Hart and Field Enterprises, Inc.

I believe that the first test of a truly great man is his humility. Really great men have a curious feeling that the greatness is not in them but through them. And they see something divine in every other man and are endlessly, incredibly merciful.

John Ruskin

Sinus Disease

John A. Coleman Jr., M.D.; Colin M. Freeman, M.D.; John W. Mahan, M.D. and Stephen E. Howery, M.D.

Abstract: "Sinusitis" is probably the most common missed self-made diagnosis today. The spectrum of sinusitis, its clinical picture, diagnosis, treatment and complications will be presented.

Sinusitis and its complications are still with us after more than three decades of antibiotics. However, every otolaryngologist daily sees patients who have misdiagnosed themselves, have been told by members of the health professions, or have learned on television that they are suffering from this malady. What then is sinusitis, how is it diagnosed and which forms of therapy are most efficacious? Before describing the clinical picture and treatment, it would be beneficial to review the anatomy and physiology.

Anatomy and Physiology

There are four pairs of sinuses. At birth, only the ethmoid sinuses are well developed. The maxillary sinuses are a small bud and enlarge with dental development. The frontal and sphenoid sinuses develop during the childhood years. Though it is uncommon, one or both frontal sinuses may be absent.[2] The maxillary, frontal, and anterior ethmoid cells communicate with the nose through the middle meatus; the posterior ethmoid cells open into the superior meatus; and the sphenoid sinuses empty into the spheno-ethmoidal recess. The paranasal sinuses are lined by pseudostratified ciliated columnar epithelium.[1] The cilia continually beat toward the nasal ostea. The lining is covered by a mucous blanket which is propelled toward the sinus osteum by the cilia.

Nasal mucous contains the bacteriolytic enzyme lyzozyme.[3] The negative pressure induced by expiration aids in normal sinus drainage.[3] In diseased states the ostea are obstructed and/or the cilia fail to function properly. There are no validated functions of the paranasal sinuses although several have been suggested, including lightening of the skull, supplementary humidification and warming of air, and adding resonance to the voice.[4]

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Sinus Headaches?

So often patients consider their facial or head pain as "sinus headache." In truth, the vast majority of these cases do not have pain related to their sinuses. Acute sinusitis does indeed produce pain much of the time, but other signs and symptoms of acute sinus disease are usually present. Chronic sinusitis does not cause pain except with an exacerbation of an acute sinusitis or with the onset of complications.[5] X-ray evidence of sinus disease is present in these diseased states.

The headache that patients refer to as a "sinus headache" usually has a vascular or muscle contraction etiology. Classic migraine is not often confused with this problem, but the vascular headache that is not in this category is frequently called "sinus headache." It tends to be bilateral and episodic. Usually no other signs of sinus disease are present.

Cluster headaches tend to occur in groups, are unilateral and are more common in men, last 30 to 60 minutes, may awaken the patient at night, and frequently have ipsilateral nasal congestion, lacrimation and redness of the eye.

Muscle contraction headaches are persistent and typically have a band-like distribution.[6]

Sinusitis

Acute sinusitis occurs as a result of turgescence and vasodilation of the nasal mucosa resulting in obstruction of ostea of the various sinuses.[7] Generalized predisposing factors include host resistance, bacterial virulence and the number of pathogenic organisms to which the host is exposed.[3] Viral infections play a large role in this condition.[3] Important local factors are excessive dryness and conditions causing nasal obstruction including allergic rhinitis, polyps, hypertrophied turbinates, vasomotor rhinitis, rhinitis medicamentosa, septal deviation, enlarged adenoids, foreign bodies, and trauma.[3]

Pain in acute sinusitis is usually aching, but may be throbbing, is worse in the head-low position and with straining and is more often noticeable in the late morning

and mid-afternoon hours.[3-6] Maxillary pain occurs over the sinus involved, the adjacent teeth, or about the corresponding eye.[3] Acute frontal sinusitis causes forehead pain. Acute sphenoidal and posterior ethmoidal sinus pain can be poorly localized, occurring in the frontal, bitemporal, occipital and/or vertex areas. Glabellar and medial canthal pain is typical of ethmoidal sinusitis.[5] Other common symptoms are a profuse anterior and posterior nasal discharge, obstruction on the involved side, a foul taste, anosmia, hyposmia, cacosmia and a low-grade fever. On examination the nasal mucosa is erythematous and edematous and a purulent discharge is present.[3] Tenderness over the involved sinus (except the sphenoid) is common. Transillumination may be of some benefit, but only **x-ray** studies will be truly diagnostic. Leukopenia of 5,000 to 6,000 is common.[8] The most common organisms are Hemophilus influenzae and Diploccus pneumoniae.[3] Other organisms include staphylococci and streptococci.[8] Obtaining an accurate culture is often difficult. Treatment is medical except with an empyema. Appropriate antiobiotic therapy should be based on the results of the sensitivity studies when available. When a Gram positive organisim is present most authorities recommend oral erythromycin, cloxacillin, tetracycline, or one of the cephalosporins. Doxycyline has been very effective for many clinicians. Intravenous medications may be necessary when the infection is severe.[3] Any treatment should continue for a minimum of 10 days.[5] Other important adjuncts include topical vasoconstrictor agents such as oxymetazoline nasal spray used two to three times daily and applied two to three times in succession with an interval of a minute or two between applications. This allows for better decongestion of the nose and ventilation of the sinuses.[7] Any topical spray should be used for a short period of time, certainly no longer than two weeks, or the rebound phenomenon of rhinitis medicamentosa may occur. Other therapeutic measures include oral decongestants and antihistamine preparations, adequate analgesia, local heat, inhalation of steam, and normal saline irrigations through the nose to remove secretions. Oral steroids may be helpful if there is an allergic component.[9]

An additional classification is **subacute sinusitis** which follows an acute infection in about 10 percent of cases.[8] Further search for the offending organism should be carried out and it should be realized that allergy may be an underlying problem. There is little or no pain or tenderness but some discomfort may remain. The chief finding is persistent purulent nasal discharge and requires additional treatment if present for more than three weeks after the onset of the acute stage.[8] In addition to the previous measures, irrigation of the sinuses such as antral puncture or other drainage procedures becomes important at this time.[5]

Chronic sinusitis is an acute infection that has persisted. Hemophilus influenzae is more likely to be a causative organism.[5] Anaerobic infections are usually found only in chronic infections.[3] This condition indicates that irreversible tissue damage has occurred in the lining of the sinus.[8] The usual lack of pain has been mentioned. Common symptoms and signs include persistent purulent drainage, nasal obstruction, anosmia, decreased hearing due to secondary serous otitis media, and increased proliferation and hyperplasia of the tissues.[5] Polyps in the middle meatus are often present in chronic infections, especially ethmoid sinusitis.[3] X-ray studies are most helpful. By and large the definitive treatment of chronic sinus disease is surgical.[7] In unresolved sinusitis, especially in the maxillary and ethmoid sinuses, the possibility of tumor should be kept in mind.

Sinusitis in Children

Sinus disease in infants and young children requires special consideration because of the difference in the time of development of the sinuses. As noted in an earlier section, the ethmoid sinuses are well developed at birth. The maxillary sinus is a small but elongated cavity at birth. As dental eruption progresses, it acquires a pyramidal shape. Adult size is reached between 15 and 18 years of age when the floor is well below the level of the nasal floor in most cases. The frontal sinus, rarely present at birth, begins to invade the frontal bone between ages two and six years and usually has no clinical significance until 10 to 12 years of age. The sphenoid sinus is a minute bud at birth, grows slowly during the first four or five years of life, then enlarges more rapidly to reach adult size in adolescence.[2]

Most sinus infections in infants and young children are usually not of long duration and are very unlikely to develop before age two or three years. Recurrent nasal infections result in enlarged adenoids which prevent proper removal of secretions. Thus, enlarged adenoids may be considered the most common underlying factor in sinus infections in children.[2] Other factors are similar to those in the adult, but special mention should be made of allergic rhinitis because of the interaction between allergy and infection. In contrast to the adult, dental infection rarely causes sinusitis in children.

In the early stages of acute sinusitis the clinical picture is that of a persistent head cold.[2] As the disease progresses and infected secretions are trapped within the sinus cavity, local and systemic symptoms become more obvious including fever and leukocytosis. In older children the symptoms and signs are similar to those in the adult. Chronic sinusitis in infants and young children

consists mainly of nasal discharge and obstruction. It should be remembered that a unilateral purulent discharge in a child is frequently due to a foreign body in the nose.

Radiographic examination is an important diagnostic aid in that x-rays reveal the presence or absence of the sinus, show whether the sinuses are large enough to be of clinical significance, indicate the extent of the involvement of the lining membrane, and may show an air-fluid level or opacification. The base view can be informative in the evaluation of the ethmoid sinuses.[2] Radiographic interpretation of involvement of the maxillary sinuses in children may be controversial and misleading.[10] There is a high incidence of abnormal radiographs in children without apparent sinus infection. This leads to the conclusion that such changes may take weeks or months to regress and in considering the frequency of infection in the preschool child, these changes may reflect a prior infection. X-ray changes may persist in the allergic child or remain indefinitely in children with cystic fibrosis.[10]

Management of sinusitis in children is similar to that discussed previously and most cases respond to good conservative management. Tetracycline during dental development should be avoided. Surgical intervention should be undertaken when there is lack of response or complications have occurred. Allergic management is most important in patients with chronic sinusitis associated with allergic involvement.

Complications include osteomyelitis, orbital and intracranial complications.[2] The most common, orbital cellulitis, is usually due to an ethmoid sinusitis. It most commonly occurs in the six to ten years old group. Symptomatically the child is quite ill with chills and fever. The eyelids are swollen and red with the palpebral fissure closed, the orbit is painful to touch and the conjunctiva is inflammed. Early, there is no proptosis and the visual acuity is not affected. If an abscess develops, there will be additional findings of muscle restriction in the principal direction of gaze, marked orbital tenderness, resistance to retropulsion, and impaired vision. An ophthalmologic consultation is imperative.

Cavernous sinus thrombosis can be a further complication and would be recognized by similar signs in the other eye, prostration, and meningismus. The more serious complications or lack of prompt resolution of the cellulitis require hospitalization and more vigorous measures.

X-Rays of the Paranasal Sinuses

Sinus x-rays are often very helpful in diagnosing and treating patients with so-called "sinus trouble." Many who think they have sinusitis have nothing but postnasal discharge, or, with headache problems, the etiology may have nothing to do with sinus disease. The standard views are the Caldwell view which is a posterior-anterior projection and best shows the frontal and ethmoid sinuses; the Water's view is a projection where the head is tilted to prevent the temporal bone from overlapping the maxillary sinuses and best shows the maxillary, frontal, and ethmoid sinuses; the lateral view shows the sphenoid sinus, ethmoid and frontal sinuses. Additional views include the submento-vertex which also shows the sphenoid, maxillary and ethmoid sinuses. Tomograms in the posterior-anterior and lateral projections are useful in special circumstances.

The commonmost reasons for ordering sinus x-rays are: 1) complaint of pain in the sinus regions, 2) abnormal nasal discharge and nasal obstruction, 3) injuries about the nose and sinus areas, 4) orbital problems such as globe displacement and diplopia, 5) investigation for nasal tumors, and 6) at times for epistaxis, particularly when the bleeding cannot be easily identified. X-rays may show muco-periosteal changes, polyp formation and fluid levels. Sinus x-rays also provide information about the condition of the bony walls of the sinuses. Enlargement of the sinus margins suggests mucocele formation wherein the continual presence of mucous production causes thinning and enlargement of the sinus. An ill-defined frontal sinus margin indicates the probability that osteomyelitis of the frontal bone has developed. Bone destruction of the maxillary sinus margins suggests a malignant tumor. The maxillary sinus is the one most often involved with malignancy. Osteomata appear very dramatically in x-rays as a dense bony mass, most commonly in the frontal and less often in the ethmoid sinuses.

There are several common sinus x-ray interpretations that need comment. The "polyp" of the floor of the maxillary sinus, unilateral or bilateral, is a mucous cyst. It is asymptomatic and usually does not require surgery. Pansinusitis, wherein all the sinuses show cloudy mucoperiosteal thickening is a frequent finding in chronic allergic rhinosinusitis. X-ray changes in a single sinus cavity alone bears further investigation, often indicating a need for drainage, tumor investigation or mucocele treatment. The report of absence of one or both frontal sinuses is not unusual, occurring about five percent of the time.

Complications of Sinusitis

Complications of sinusitis are not common, but do occur despite proper medical treatment. Contributory factors may be poor host resistance, inadequate drainage, resistance to antibiotics, extension along

preformed pathways or retrograde thrombophlebitis. The anatomic proximity of the sinuses, as well as the venous relationships, to the orbit, intracranial structures, and oral cavity account for extension to these areas.

Classification of complications includes: 1) Orbital extension resulting in orbital cellulitis or abscess. The clinical features and treatment have been previously described. 2) Intracranial extension including meningitis, epidural abscess, subdural abscess, frontal lobe abscess, and cavernous sinus thrombosis. Acute infections or acute exacerbations of chronic infections produce intracranial complications more often than chronic sinusitis. 3) Osteomyelitis of the frontal bone, maxilla, and the sphenoid bone are serious complications, the latter two being rare.[12] Frontal osteomyelitis is characterizd by dull local pain and headache which may be insidious. Edema is present and if a subperiosteal abscess forms (Pott's puffy tumor) a doughy swelling will be present. X-ray findings may be delayed from seven to 14 days, but will show necrosis, abscess and later sequestration of bone. Treatment includes intravenous antibiotics and surgery.[12] 4) Other complications include: A) Superior orbital fissure syndrome with involvement of the third, fourth and sixth cranial nerve and the first division of the trigeminal nerve. There may be ocular and forehead pain, exophthalmos, ophthalmoplegia and blindness. B) Oro-antral fistula resulting from erosion of bone into the oral cavity is more common after a dental infection or extraction of a molar or pre-molar tooth. Medical management may result in closure but often surgical repair is necessary. C) Mucocele or pyocele results from a sinus becoming sealed off and infected. The frontal and ethmoid sinuses are the most common sites with bone erosion and displacement of the eye.[5]

Surgical Treatment

Surgery of the paranasal sinuses is recommended for: 1) Acute infections. Although the vast majority of cases respond to medical therapy, it is sometimes necessary to irrigate the antrum in case of an empyema, but this procedure is usually done in the subacute stage. The sinus can be approached through the inferior meatus, the natural osteum, or through the canine fossa. In frontal sinusitis if there is not a prompt response to treatment or a fluid level persists, it will be necessary to perform a trephining procedure. The floor of the sinus just under the eyebrow is opened and a drain is inserted. 2) Subacute sinusitis. Antral lavage is the commonest procedure at this stage and in some cases a nasal antrostomy may be indicated at this time or because of recurrent acute infections. 3) Chronic sinusitis. This condition usually indicates irreversible changes in the sinus lining. The most frequent procedure is a Caldwell-Luc procedure whereby the antrum is opened through a sublabial approach, the disease lining is removed, and a nasal antrostomy is created. Ethmoidectomy, either by an intranasal or extranasal approach, is performed for unresolved symptomatic ethmoid disease or complications from disease. Chronic frontal sinusitis may require obliterative surgery as described below. A nasal polypectomy may be an integral part of any of the above procedures. 4) Complications. When an underlying frontal sinusitis is the source of an intracranial complication, the current treatment of choice after resolution of the intracranial problem is obliteration of the frontal sinus with abdominal fat.[12] This same procedure may be used for frontal pyocele, mucocele, and after resolution of an osteomyelitis caused by sinusitis.

Conclusion

An awareness of the spectrum of sinusitis is important to all primary care physicians. With prompt diagnosis and adequate treatment, serious complications can be avoided.

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Advice is like snow; the softer it falls, the longer it dwells upon, and the deeper it sinks into the mind.

—Samuel Taylor Coleridge

Facial Rehabilitation After Mid-Face Trauma

Marc S. Karlan, M.D.

Abstract: The cosmetic results of reconstructive surgery after mid-face trauma are impressive yet frequently flawed. Results are significantly improved by: 1) *direct visual* alignment of both *hard* and soft tissues; 2) accurate geometric alignment in *three dimensions*; and 3) direct interosseous fixation. Basic geometry requires alignment at *three points* of a fracture for accurate hard tissue alignment. The surgeon must be prepared to bone graft for stability. Moire contour analysis is of assistance in late repairs. Cases are reported and discussed with regard to these principles.

"The face is the mirror of the soul." Indeed, presentation of a normal pleasing facade is a most important function of the face. Other functions of the face include respiration, vision, alimentation and audition. Not surprisingly, we as surgeons are quite successful in achieving optimal results with concern to these latter functions. However, successful cosmetic repair is not always optimal.

The surgeon must approach the face in planning repair of post-traumatic deformities with one primary consideration: the return of function.

It has been shown that cosmetic repair is often less than optimal.[2,3] Patient acceptance is based more on the resilience of the human spirit rather than the precision of our repairs. Analysis of zygomatic fracture results has lead us to generalize for all maxillofacial work the following principles: 1) direct visual alignment of hard, as well as soft tissues, is an essential step toward optimal rehabilitation, 2) accurate geometric alignment must be in three dimensions, and, 3) stability is best achieved with interosseous fixation techniques. Alignment of three dimensional objects requires direct visual inspection of at least three points of the fracture, not the usual two, used in many routine surgical procedures on mid-face fractures. Two point alignment leaves accurate alignment to chance (Fig. 1). Stable fixation requires bone-to-bone contact. In late repairs, refracture alone is usually insufficient, since remodeling of the skeleton has occurred by resorption of overriding bone. Borrowing from our experience in craniofacial work, bone grafting (rib or iliac crest) is used without hesitation. Wire fixation techniques are the ideal for the repair of these fractures. Cotton packing is inadequate for primary stabilization and should be used only as an adjunct when stable fixation by wire is not possible.

To provide even more geometric accuracy, we have gone one step further in our craniofacial and maxillofacial reconstruction. We use biostereometric techniques for contour analysis and topographic mapping of the deformities.[1, 4–7] This provides quantitative as well as qualitative visual information (Fig. 2). In fact this is also used in our craniofacial and cosmetic surgery.

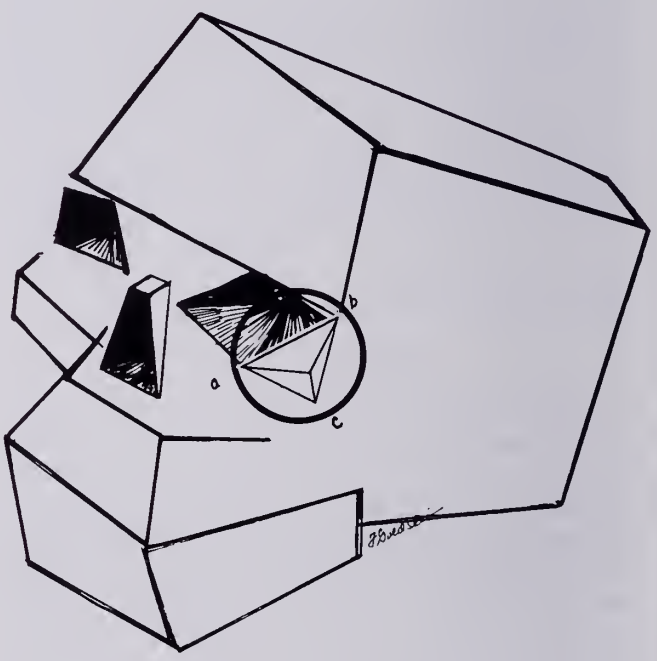


Fig. 1. — The illustration is an abstract model of a skull with a geometric approximation of the zygomatic malar complex as a pyramid. The corners of the pyramid should normally be aligned with the reference circle. Note that in the standard surgical techniques which align the infraorbital rim and the zygomatic frontal suture, the third point and the apex of the pyramid may be malaligned. (To be printed in Archives of Otolaryngology)

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Case Reports

1. A 54-year-old white male presented for facial rehabilitation after zygomatic fracture. The patient had open reduction internal fixation of his zygomatic fracture, 19 days after the trauma. The operative note recorded that osteotomies were necessary for mobilization and that instability persisted after fixation by interosseous wiring of the infraorbital rim and the zygomatic frontal suture. Antral packing was used. Bone gaps were noted in the inferior fracture lines due to the bone remodeling that had occurred. They were left alone.

On physical examination the patient was found to be profoundly deaf (bilaterally pure tone threshold 100 dB, HTL ANSI 1969) and blind (bilateral cataracts). There was marked depression of the right malar eminence (Fig. 2). Other pertinent findings include full range of motion of the mandible, right infraorbital hypesthesia and normal extraocular motions without enophthalmos. Since the cosmetic deformity was not thought to be of prime concern for this otherwise disabled man, no further maxillofacial surgery was recommended. Ophthalmologic surgery was recommended and his left cataract was removed.

2. A 35-year-old white male presented three and one half months after zygomatic fracture and open reduction of the fracture. His chief complaint was of inability to open his mouth fully. He also noted facial asymmetry. There was no enophthalmos; extraocular motions were intact. Upon examination the coronoid process was found to impinge on the malar complex. X-ray examination showed a comminuted fracture of the malar eminence with residual separation of many of the fragments. After work up, the fractured zygoma was explored. Multiple osteotomies in the old fracture lines were made and areas of significant gaps were realigned. There was noted to be residual gapping inferiorly where there had been bone remodeling in the area of overriding fragments. This area was grafted with iliac crest to provide stability. Postoperatively the patient did well and had complete return of his range of motion of the mandible and normal facial symmetry.

3. A 35-year-old male was admitted with multiple facial fractures five days after being severely beaten.



Fig. 2. — Patient 1. Moire topography with contour lines at 1.8 mm intervals. Note the vertical orientation of the contour lines over the right malar eminence compared with the patient's normal left side. The displacement in the ¾ view of cheek contour. Fringe measurements reveal a depression of 9 mm.

Both mandibular and mid-face fractures were identified. The maxilla was "floating" and the dorsum of the nose was flattened. After a tracheostomy was performed, an open reduction of the mandibular fracture was achieved. Inter-maxillary fixation was accomplished with arch bars. The mid-face fracture was then repaired by direct wiring of the front zygomatic suture lines. Infraciliary incisions were used to explore the orbital rims and floors. Direct wiring was possible on the right side, but because of the severe comminution on the left, this could not be done. Bilateral Caldwell-Lucs were done, and the floors of the orbit were packed. Drop wires were then placed from the frontal zygomatic suture lines to the mandibular arch bars. The nasal fracture was reduced and packing was placed in the nose. Postoperatively the patient did well and the cosmetic and functional results were excellent. Note that meticulous explorations of multiple fracture points allowed good geometric alignment of the pieces (Fig. 4).

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Fig. 3. — Preoperative (a) there is 7.2 mm of malar recession in a patient with zygomatic fracture. Postoperative, (b), there is a residual asymmetry of 1.8 mm. This patient had three point visual alignment at the infraorbital rim, the zygomatic frontal suture and the maxillary buttress.



Fig. 4. — Patient 3. Note good cosmetic result after open reduction and alignment of fractures at multiple points. Preoperative (A); Postoperative (B).

Discussion

These three case reports emphasize that alert and careful implementation of standard surgical techniques and basic geometric logic is essential to successful facial rehabilitation.

The first case emphasizes that the surgeon must be aware of the remodeling of each fracture point. If late repair is undertaken, this remodeling must be estimated. The art of our surgery then becomes more obvious. Fractures that have been remodeling for only two to three weeks may require grafts to provide alignment and long term stability. The surgeon must be prepared and willing to complete his repair.

In the second case, the surgeon's willingness to compromise when faced with difficult alignment problems of the jigsaw puzzle, lead not only to poor cosmesis but actual compromise of alimentary function. Visual alignment of hard tissues is an essential step in our procedures. Closed techniques for zygomatic fractures have no place except perhaps in times when triage is necessary. Even in mandibular fractures closed techniques rely on visual alignment of hard structures, the teeth. Mid-face fractures must also be visually aligned. If there is more than one piece, or more than one fracture line, when you are dealing with a three dimensional object, alignment at three points is essential.

In summary, functional rehabilitation after mid-face fractures is best achieved by the standard techniques in our armamentarium. Exacting attention to detail is essential. Visual three point alignment and stable bone-to-bone fixation techniques are optimal.

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The authors wish to express their appreciation for the assistance and contributions of Dr. Nicholas J. Cassisi.

Worry affects the circulation — the heart, the glands, the whole nervous system. I have never known a man who died from overwork, but many who died from doubt.

Charles H. Mayo

Fractures of the Facial Skeleton

William King Stubbs, M.D., F.A.C.S.

Abstract: This paper on facial fractures describes several common types of facial bone injury and outlines standard methods of management. The complexity of this field is great and requires a detailed knowledge on the part of the surgeon of the various skeletal and physiological derangements which can occur with facial injury. Illustration of typical clinical and radiological findings are presented. Complicating factors such as fractures in children, or the edentulous mandible or maxilla are beyond the scope of this article. Particular attention is given to fractures of the malar bone and the maxilla.

Fractures of the facial skeleton are frequently caused by automobile accidents. With the advent of seatbelts and lower speed limits, automobile victims are more likely to survive the initial impact and arrive in the emergency room. The majority of these patients will have sustained trauma to the head and neck area. The primary management of such patients must proceed in an orderly fashion. The establishment of an airway may be urgent in the patient with midfacial or mandibular fractures. Displaced dentures, clots, or debris may compromise the oral cavity or hypopharynx. Posterior displacement of the tongue or supraglottic larynx may accompany facial trauma and create a threat to the airway. Nasal hemorrhage can usually be controlled with anterior and/or posterior packing. Injuries to the brain or cervical spine must be ruled out with appropriate clinical and x-ray studies prior to definitive treatment of a facial fracture. The otolaryngologist may require consultation with a neurosurgeon, ophthalmologist or oral surgeon. Soft tissue injuries, such as lacerations or avulsions of the skin of the face, when accompanying facial fractures, should be repaired as soon as practical. Thoracic, abdominal, and extremity injuries take priority over definitive management of the fractured facial bone. Fracture repair may be delayed as long as a week, until the patient's general condition is stable or edema has subsided.

In the treatment of facial fractures, the goal of the surgeon is restoration of form and function. Eye movements and position are of primary importance. Facial disfigurement, neural injury and malocclusion can generally be avoided or minimized with properly performed surgery. Obstruction of the nasal airway and interference with drainage of the paranasal sinuses must be recognized and repaired.

A description of some of the more common types of facial bone injury follows with emphasis on the diagnostic findings and management.

Fractures of the Malar Bone

The malar bone, or zygoma, forms the boney framework for the prominence of the cheek. The orbit, maxillary sinus, and zygomatic arch are dependent on the zygoma for their structural integrity. The classical malar, or "tripod," fracture results from a lateral force applied to the cheek. The malar bone typically fractures through its weakest portions; these areas are the rim of the orbit at the infraorbital foramen, the



Fig. 1. — Fracture of right malar bone showing an irregularity in the orbital floor and in the lateral wall of the right maxillary sinus. An air fluid level is present in the right maxillary sinus indicating bleeding into the sinus from the fracture.

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zygomaticofrontal suture line, the lateral wall of the maxillary sinus, and the zygomatic arch (Fig. 1).

Physical findings in a "tripod" fracture are typical. Downward and posterior dislocation of the fractured zygoma causes visible flattening of the prominence of the cheek. Entrapment of periorbital fat or of extraocular muscle into the fragmented orbital floor may result in diplopia and enophthalmos. Hypesthesia of the face in the distribution of the infraorbital nerve occurs. Epistaxis may result from disruption of the antral mucosa. Medial displacement of the zygomatic arch with impingement on the coronoid process of the mandible may interfere with the opening of the jaw.

Repair of a malar fracture should restore the contour of the cheek, free entrapped periorbital tissue, and decompress the infraorbital nerve. Several surgical approaches have been described. Direct inspection of the orbital floor through an infraorbital incision is necessary to assure satisfactory reduction of the displaced orbital rim. A separate incision in the lateral aspect of the eyebrow is used to expose the zygomaticofrontal suture line. Access through the brow incision permits elevation of the zygomatic arch as well. The fracture can usually be reduced with anterior and lateral force applied by an instrument passed posterior to the zygoma through the brow incision (Fig. 2). Stainless steel wires placed through a drill hole on either side of the fracture site at the infraorbital rim and zygomaticofrontal suture will maintain reduction in unstable fractures. A severely commuted fracture of the orbital floor may require an implant such as silastic sheeting or tantalum mesh to support the globe. If necessary, additional support for the orbital floor can be provided for several weeks with gauze packing placed into the maxillary sinus floor through an antrostomy.

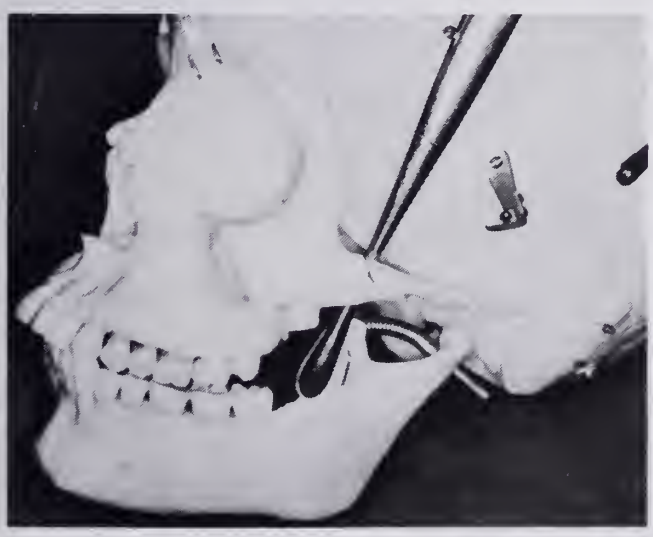


Fig. 2. — A blunt elevator is passed medial to the zygomatic arch through a small incision in the scalp, and pressure is applied to accomplish reduction of a depressed malar fracture.

A worrisome late complication of a malar fracture is enophthalmos. Enophthalmos results from sagging of the floor of the orbit or from a reduction in the volume of the orbital contents as traumatized periorbital fat is absorbed. Proper repair of any malar fracture with clinical evidence of significant displacement lessens the chance of this complication.

Blow-Out Fracture

A separate type of fracture of the orbital floor results from a direct blow to the eye (Fig. 3). Force applied to the globe which is not partially cushioned by the protective boney orbital rim may cause an isolated disruption of the orbital floor, the so-called "blow-out" (Fig. 4). The fracture usually occurs at the thinnest portion of the orbital floor adjacent to the canal of the infraorbital nerve. Fifty percent of such accidents occur from

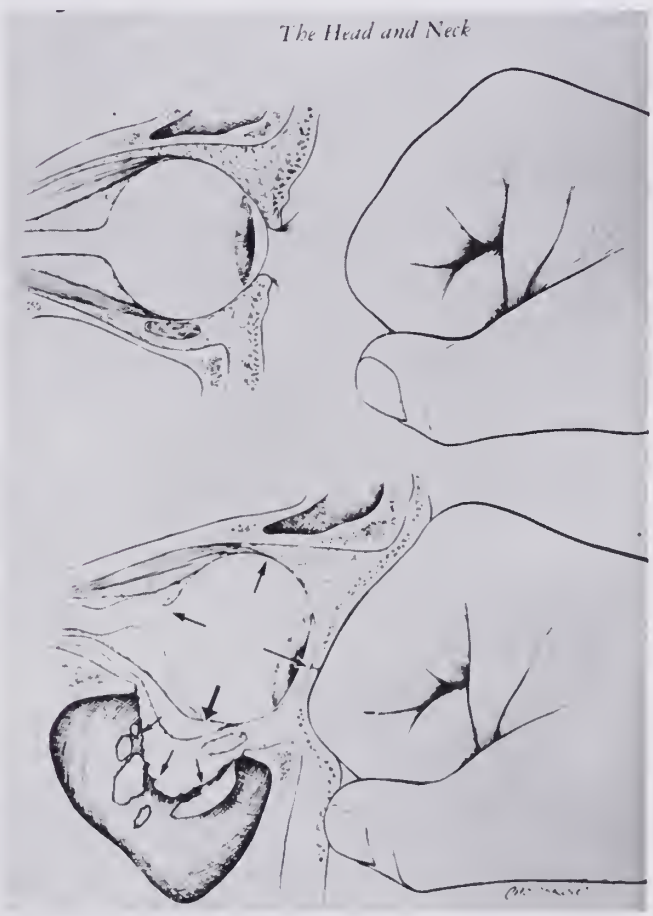


Fig. 3. — A frequent cause of blow-out fracture is the human fist, which penetrates the protective barrier formed by the rim of the orbit, causing increased intraorbital pressure and a blow-out at the weakest point of the orbital floor.[2]

Courtesy of W.B. Saunders Company, from Reconstructive Plastic Surgery, Vol. 2, page 754, 1977.



Fig. 4. — This Water's view of the skull demonstrates density in the roof of the right maxillary sinus. This "inverted polyp sign" is indicative of a blow-out fracture of the orbit.

striking a dashboard or steering wheel; the human fist accounts for about 20%, while a ball, elbow, or fall account for most of the remainder.[1] Physical findings of a blow-out fracture are limitation of motion of the eye on upward gaze, infraorbital hypesthesia, and enophthalmos. Ophthalmologic evaluation is indicated to rule out vitreous hemorrhage or retinal detachment. X-rays may reveal a soft tissue density in the roof of the maxillary sinus resulting from herniation of the orbital contents into the sinus cavity. In some cases, tomography may be useful in establishing the diagnosis.

Surgical repair requires inspection of the orbital floor through an incision in the skin of the lower eyelid. Periorbital contents which have been displaced into the maxillary sinus are elevated and support for the globe is provided.

Fractures of the Maxilla

Fractures of the maxilla result from frontal trauma to the midface. Dashboard and steering wheel injuries account for the majority of these fractures. The bones of the face tend to break in a predictable manner when struck by a frontal blow. The location of the fracture lines is determined by the position of the solid buttresses and the areas of thin bone in the human skull. The exact vector of the force applied to the skull determines which thin area of bone will fracture. The predictable pattern of fractures of the midface permits classification in the clinically useful manner described by LeForte.[3] The LeForte I fracture is a horizontal break of the maxilla above the apices of the teeth. The LeForte II injury is a pyramidal fracture of the midface extending through both orbital floors. The resulting "pyramid" includes the external nose and upper dental arch. The LeForte III fracture, which separates the bone of the midface from the skull, is also referred to as a craniofacial disjunction. The fracture extends through both zygomaticofrontal suture lines, the nasofrontal suture, and the orbital floors. The entire midface is then attached to the skull only by soft tissue. Assorted combinations and variations occur in the standard LeForte classification.

Clinical findings are usually apparent in midfacial fractures. To and fro motion applied to the incisor teeth will demonstrate mobility of the maxilla if the fracture is not too severely impacted. Palpable "step-down" deformities in the orbital rims reveal fractures in this area. If significant posterior displacement has occurred in a LeForte II or III fracture, the midface will assume characteristic "dishface" appearance, with the maxilla recessed posteriorly. Malocclusion with anterior open bite deformity occurs with displacement of the maxilla (Fig. 5a).

The patient with a midfacial fracture has experienced significant trauma. Injuries to other parts of the body, especially the brain and cervical spine, must be recognized and treated. Severe fractures with comminution of the ethmoid labyrinth or frontal sinus may result in cerebrospinal fluid rhinorrhea. Damage to the eye or lacrimal system may occur. Fractures of the mandible may also be present.

Repair of a midfacial fracture can usually be performed within one week of injury. Anesthesia is administered through a nasotracheal tube or



Fig. 5a. — A lateral view of the facial bones in a patient with a LeForte II fracture, indicating an anterior "open bite" deformity. There is posterior displacement of the maxilla.



Fig. 5b. — Postoperative view of the same patient showing reestablishment of normal dental occlusion. The maxilla has been replaced in its normal anatomical position. A stainless steel suspension wire passes from the zygomatic arch to the dental arch bar.



Fig. 6. — An external halo device secured to the outer table of the skull is used to provide continuous anterior traction to maintain reduction of a severely displaced LeForte III fracture.

tracheotomy. The underlying principle for treating any broken bones applies to surgical treatment of the fractured maxilla; i.e., the dislocated fragments must be repositioned and immobilized for proper healing to occur. At the time of surgery, the maxilla and the mandible are secured to one another in proper dental occlusion with arch bars and interdental fixation. Forward traction on the maxilla will disimpact a fresh fracture. Immobilization is obtained by securing the mobile maxilla to the stable frontal bone or zygomatic arch with stainless steel suspension wires attached to the arch bar of the maxilla (Fig. 5b). Immobilization should be maintained for at least 4 to 6 weeks. In an occasional case, an external device such as a halo secured to the outer table of the skull may be required to provide continuous anterior traction (Fig. 6).

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Man is meant for happiness and this happiness is in him, in the satisfaction of the daily needs of his existence.

Leo Tolstoy

The Surgical Treatment of Nasal Skin Cancer

Ferdinand F. Becker, M.D., F.A.C.S.

Abstract: The etiology of nasal skin cancer is discussed and the most common types are reviewed. Surgical excision is the treatment of choice and the merits of different methods of removal are recounted. The reconstruction of defects created by ablation of nasal skin cancer is emphasized and illustrated.

Cancer occurs more often on the skin of the nose than any other organ of the body.[1] Prolonged sun exposure has a cumulative effect on the skin and causes actinic damage which eventually leads to neoplasia. Because it projects from the face, the skin of the nose receives more damaging actinic rays than any other part of the body. The incidence of nasal skin cancer increases from the root of the nose to the tip, as does the projection of the skin. Cancer is uncommon in the columella area which has relatively little sun exposure. The skin cancer rate in North America doubles for each 3° 48′ latitude (or 265 miles further south).[2] This makes nasal skin cancer a very common problem in the sunbelt states, particularly in south Florida, the southernmost projection of the continent. Past exposure to ionizing irradiation in the treatment of acne and other benign head and neck diseases has been shown to be associated with a very high incidence of nasal and facial skin cancers.[3,4] One third of the cases of cancer of the nose have had another head and neck skin cancer at the same time or had one in the past.

Types of Nasal Skin Cancer

Basal Cell Carcinoma is by far the most common type of nasal skin cancer and accounts for more than 85% of the cases in most series. The most common type of basal cell carcinoma is a translucent papule with teleangiectatic vessels over its surface (Fig. 1a). As it enlarges a depressed center develops with a rolled edge and necrosis eventually develops in the crater (Fig. 1b). Other more uncommon varieties of basal cell carcinoma that are encountered are the ulceronodular and the enlarging pore.[4] The morphea-type basal cell carcinoma is a whitish or yellow plaque which is slightly depressed (Fig. 1c). It is more difficult to diagnose because of the subtle appearance and considerably more difficult to treat because of the indistinct clinical and surgical margins.

Squamous Cell Carcinoma accounts for less than 15% of most series of nasal skin cancer. It is an ulcerative tumor with indurated margins and in a significant number of late cases is associated with metastases to the neck or parotid gland lymph nodes. It occasionally infiltrates bone and cartilage and tends to be much more aggressive than basal cell carcinoma (Fig. 1d).[5]

Malignant Melanoma of the skin of the nose is rare but when it occurs it is almost invariably of the lentigo maligna melanoma variety. This lesion is a tan or brown macule with areas or flecks of black pigmentation with an irregular outline (Fig. 1e). The salient features of this disorder and its surgical treatment were recently reviewed by the author.[6]

Keratoacanthoma is a peculiar tumor which can be confused both clinically and histopathologically with squamous cell carcinoma. It goes through successive stages of rapid growth, stability, and involution over a two to eight month period and is quite common on the nose (Fig. 1f). Although this lesion is benign, it is included here because malignant transformation has been reported and it is recommended that these lesions be removed conservatively.[7]

Other forms of skin cancer which occur on the nose are Bowen's disease, sebaceous gland carcinoma, and basosquamous carcinoma.

Treatment

The prominent position and aesthetic value of the nose encourages early diagnosis of cancer but often complicates the treatment. The patient's demands for a normal cosmetic appearance and the surgeon's desire for minimal scarring occasionally lead to inadequate tumor removal and recurrent disease. This fear of deformity led many physicians to use radiation treatment defensively in years past. Recurrences following this

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Fig. 1. — a. Nodular basal cell carcinoma.



Fig. 1. — b. Advanced basal cell carcinoma.



Fig. 1. — c. Morphea-type basal cell carcinoma, lesion involved skin of the entire left lateral lower nose.



Fig. 1. — d. Advanced squamous cell carcinoma, present three years.

form of therapy often are extensive, poorly defined tumors which are difficult problems to ablate and reconstruct. Cancer of the skin of the nose must be treated with adequate surgical removal and appropriate reconstruction when indicated.

Types of Surgical Ablation of Nasal Skin Cancer

Curettage and Electrodesiccation with secondary healing is used extensively by dermatologists with excellent cure rates and mostly adequate cosmetic

results in small lesions. Unfortunately, adequacy of excision cannot be judged by microscopic examination.

Surgical Excision with primary closure can give satisfactory cure rates but is only applicable to small lesions on the nose. There is a strong tendency to develop narrow margins of excision in an effort to minimize scarring, making inadequate excision an ever present danger. If the edges of the defect are beveled toward the center after surgical excision, healing by secondary intention can give excellent results in selected cases. Surgical excision with immediate reconstruction is the most frequently used form of treatment for large lesions.

Electrocautery alone without microscopic diagnosis is to be condemned, but it is often requested and expected by the patient.

Cryosurgery has become popular with some dermatologic surgeons[8] but does not seem to offer significant advantages over current modalities and has the disadvantage of cumbersome technique and equipment.

Mohs' Technique of microscopically controlled excision of skin cancer enjoys the highest cure rate of any modality.[9] The entire undersurface of the excision is mapped and examined microscopically in stages to insure complete tumor removal. This technique has been adapted in recent years to fresh tissue and fixation with zinc chloride paste and is used only in extensive lesions. This technique also preserves more normal tissue than any other method. Mohs' excision is most useful in recurrent basal cell carcinoma and morphea-type basal cell carcinoma. Both of these lesions have indistinct clinical margins and hidden nests of neoplasia deep within fibrous tissue causing recurrence after conventional surgery in a large percentage of cases.[10]

Reconstruction of Nasal Defects Following Ablation of Nasal Skin Cancer

Reconstruction should be undertaken when complete tumor removal is reasonably certain. If cure is doubtful, the defect should be allowed to heal by secondary intention and observed. Most cases of primary skin cancer should be cured on initial treatment and reconstruction can begin immediately. Cases of recurrent skin cancer and morphea type basal cell carcinoma may require microscopically controlled excision. The philosophy of and indications for reconstruction of the resulting defects have been dealt with previously.[11]

If primary closure or secondary healing of nasal defects are not likely to produce good functional or cosmetic results, the following reconstructive measures are available:

Skin Grafts. Split thickness skin grafts are thin and tend to retract and are not recommended in nasal reconstruction. Full thickness skin grafts are useful in defects of the upper lateral nose and inner canthus area and in some small defects on the tip of the nose if the nasal tip skin is thin. If the nasal tip is thick, they should not be used in this area. The skin donor sites found most useful are postauricular, supraclavicular, and upper eyelid. Short of these special indications, grafts are generally unsatisfactory in nasal reconstruction. Healing by secondary intention on the nose often gives a more pleasing result than skin grafting.



Fig. 1. — e. Lentigo Maligna Melanoma, level II invasion.



Fig. 1. — f. Keratoacanthoma, present only four weeks.



Fig. 2. — a. Defect resulting from removal of recurrent basal cell carcinoma.



Fig. 2. — b. Composite auricular graft, sutured into place.



Fig. 2. — c. Appearance of graft six days postoperatively, note early vascularization of inferior portion of graft.



Fig. 2. — d. Result one year later.



Fig. 3. — a. Basal Cell Carcinoma of inner canthus area with glabellar flap outlined.



Fig. 3. — b. Tumor excised, flap elevated.



Fig. 3. — c. Flap rotated into place, donor site closed in natural glabellar frown line.



Fig. 4. — b. Lesion excised, flap elevated.



Fig. 3. — d. Postoperative result.



Fig. 4. — c. Flap rotated into place, donor site closed in natural nasolabial fold.



Fig. 4. — a. Basal Cell Carcinoma left nasal dorsum, nasolabial flap outlined.



Fig. 4. — d. Postoperative result.



Fig. 5. — a. Lentigo Maligna of nose, rhomboid flap outlined.



Fig. 5. — d. Postoperative result.



Fig. 5. — b. Lesion excised, flap elevated.



Fig. 6. — a. Recurrent basal cell carcinoma of left nasal ala.

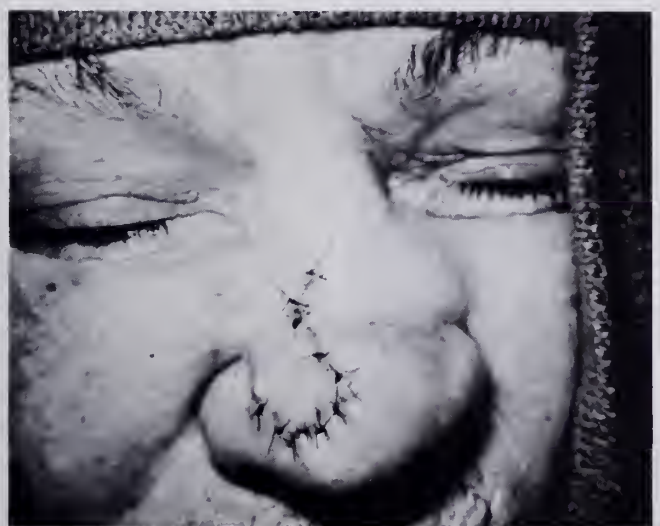


Fig. 5. — c. Flap rotated into place, donor site closed.



Fig. 6. — b. Erosion into nasal vestibule.



Fig. 6. — c. Lesion excised, inner lining provided by nasal septal compound cartilage and mucosal flap, midline forehead flap elevated.



Fig. 6. — d. Flap in place three weeks postoperatively, awaiting flap release.

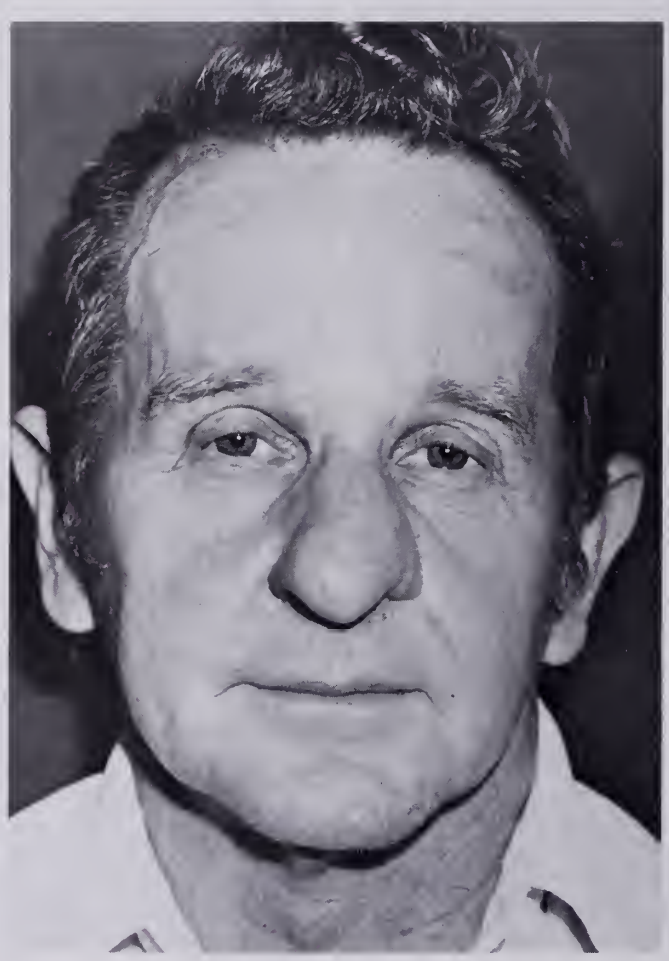


Fig. 6. — e. Postoperative result, front view.

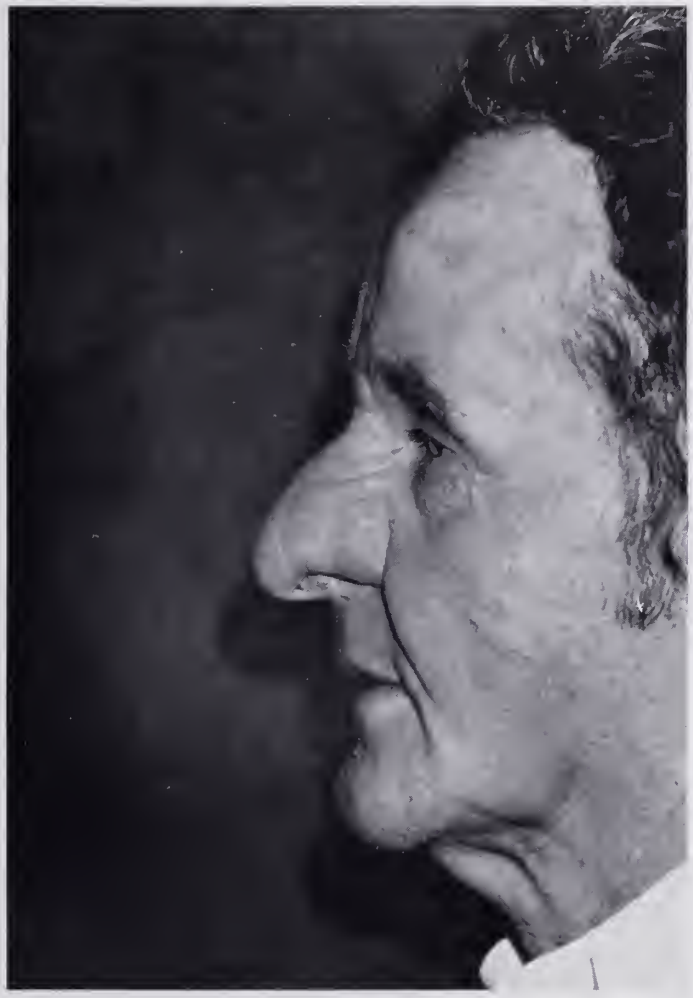


Fig. 6. — f. Postoperative result, lateral view.

Composite Grafts. Placement of a composite auricular graft is the treatment of choice for a repair of a full thickness defect in the nasal ala, columella, and dorsum of the nose if it is less than 2.0 cm in diameter (Fig. 2.).

Skin Flaps. Local or regional skin flaps have several advantages over grafts. They carry their own blood supply and therefore are not dependent on the recipient site for survival. They provide bulk and superior protection to underlying bone, cartilage, and neurovascular structures. On the nose, local tissues provide far better color and texture match than skin grafts. Some of the flaps which we have found useful in nasal reconstruction will be described and illustrated:

A. The **glabellar flap** is very useful in closing defects of the upper nose and inner canthal area (Fig. 3). The underlying muscles can be incorporated for bulk, but the flap is limited by the amount of tissue that it can supply. The donor site is closed in a natural frown line.

B. The **nasolabial flap** is useful for a variety of defects of the nasal ala and lateral nose. It has the advantage of abundant mobile cheek tissue and primary closure of the donor site in the natural nasolabial sulcus. This flap may have a superior or inferior base. This is perhaps the most useful flap in nasal reconstruction (Fig. 4).

C. The **advancement cheek flap** is useful for lateral nasal defects. The superior limb is in a natural skin fold in the infraorbital area and should be swung superiorly to the level of the lateral canthus laterally to prevent ectropion. The inferior limb is in the nasolabial sulcus. After this flap is advanced, excess tissue must be excised from the edges of the flap.

D. The **rhomboid flap** has been found to be useful in nasal reconstruction (Fig. 5). This flap has been well described in the past and the details will not be explored in this presentation.[12 13]

E. The **midline forehead flap** has been used for many centuries and is still the workhorse flap for subtotal nasal reconstruction. The flap is developed from midline forehead tissue down to the pericranium. It is left attached for a month and then the pedicle is divided and the remaining flap is restored to its position on the forehead. This flap is illustrated in Figure 6.

F. The **island forehead flap** has been found to be useful in large defects of the center portion of the nose.[14] It has the advantage of a one stage reconstruction without the necessity of a secondary operation to divide the flap pedicle. The blood supply of this flap can be tenuous and it should be used with caution only by experienced reconstructive surgeons.

G. The **scalping flap** is the most useful for total nasal reconstruction and has been well demonstrated by Converse and Conley.[14,15]

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No horse gets anywhere until he is harnessed,
No steam or gas ever drive anything until it is confined,
No Niagara is ever turned into light and power until it is tunneled
No life ever grows great until it is focused, dedicated and disciplined.

Harry Emerson Fosdick

Resurfacing Facial Defects With Local Skin Flaps In Opposition to the Use of Skin Grafts

R. Glenn Neel, M.D.

Abstract: Several skin flaps which are useful in the reconstruction of facial defects are demonstrated and discussed. Specific indications for skin grafting are listed, but local flaps generally give a better cosmetic appearance on the face.

Direct closure of elliptical defects following excision of facial lesions is the preferred procedure; however, some defects are too large and primary simple closure would distort the local anatomy resulting in dog ear defects or excessively wide scars if closed in this manner.

Since the early fifties, there has been an ever increasing use of local and regional flaps to resurface facial defects, not only to satisfy the exacting nature of the surgeon, but to avoid patient dissatisfaction with the cosmetic appearance which often results from the use of skin grafts. We have all witnessed the difference in skin texture, the secondary contracture, or the telltale difference in skin color afforded by skin grafts in the head and neck area.

The excellent blood supply, good elasticity, and natural skin creases of facial skin (particularly in the aged) have been the stimulating incentives for a few perceptive surgeons to design flaps and transpose segments of viable tissue to resurface facial defects in a more aesthetically pleasing and functional manner.

It is not within the scope of this paper to cover all facial flaps, or explore their design in depth, but to mention and demonstrate only a few which have been found useful.

Skin grafts continue to be used in the following specific conditions.

1. Small lesions of the nasal tip.

2. When tumor recurrence is a distinct possibility and split thickness grafts are used as a temporary measure or to observe for recurrence.

3. When the defect is a very large one as in burns or very large malignant skin tumor, flaps are often not feasible.

4. When local skin is not available for resurfacing as in severe facial scarring, previously irradiated skin or skin which has severe actinic damage.

The following six flaps which are useful in facial reconstruction are briefly discussed and demonstrated.

1. The **nasolabial flap** is designed from cheek tissue lateral to the nose and can be based either superiorly or inferiorly. It is particularly useful for defects of the lower one-half of the nose and upper lip area (Fig. 1).

2. The **bilobed flap** (Zimany) is a transposition flap which consists of moving a large lobe to fill the defect and a smaller lobe to fill the donor site. The two lobes are at right angles to each other and the smaller second donor area is closed directly. This flap is useful in large defects of the cheek area (Fig. 2).

3. The **rhomboid flap** (Limberg) is a transposition flap with an exacting geometric design. This is a most useful small flap in the facial area and is highly recommended for defects of the nose, cheeks, temples, and neck (Fig. 3).

4. The **midline forehead flap** is an extremely useful flap for resurfacing large defects of the nose. The donor site can be closed primarily with good cosmetic results. A second stage to detach the pedicule is performed in four to six weeks (Fig. 4).

5. The **island forehead flap** has a subcutaneous pedicle carrying the blood supply and is transported beneath a tunnel in the subcutaneous tissue to the defect in the nasal-cheek area. This flap is useful in upper nasal and medial large canthal defects (Fig. 5). Extreme care must be taken to avoid injuring the blood supply from the supratrochlear vessels. Because of the tenuous blood supply, this flap should be used only by experienced reconstructive surgeons.

In some cases, more than one flap is required. Demonstrated in Figure 6 is the combination of an advancement and rotational flap used to cover a rather deep defect of the scalp and forehead area.

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(See illustrations next page)



FIGURE 1

A. Recurrent basal carcinoma of the left alar rim with a superiorly based nasal labial groove flap.
B. Tumor excised, flap rotated and sutured in position. Donor site closed in the nasal labial groove.
C. Postoperative results.



FIGURE 2.

A. Recurrent basal cell carcinoma after irradiation with design for bilobed or Zimany flap.
B. Flap after transposing and suturing.
C. Postoperative results.



FIGURE 3

A. Basal cell carcinoma of chin with rhomboid design around tumor and outline of Limberg flap.
B. Defect and flap elevated.
C. Flap transposed and sutured in defect. Donor site should be closed prior to suturing flap.
D. Postoperative results.



FIGURE 4

A. Recurrent basal cell carcinoma of lower dorsum of nose.
B. Resulting defect involving approximately one-half of nose.
C. Midline forehead flap transposed into position and donor site being approximated in mid-

development of distal blood supply.

E. Second stage after dividing and fashioning two, and one-half weeks after first stage.

F. Postoperative results.

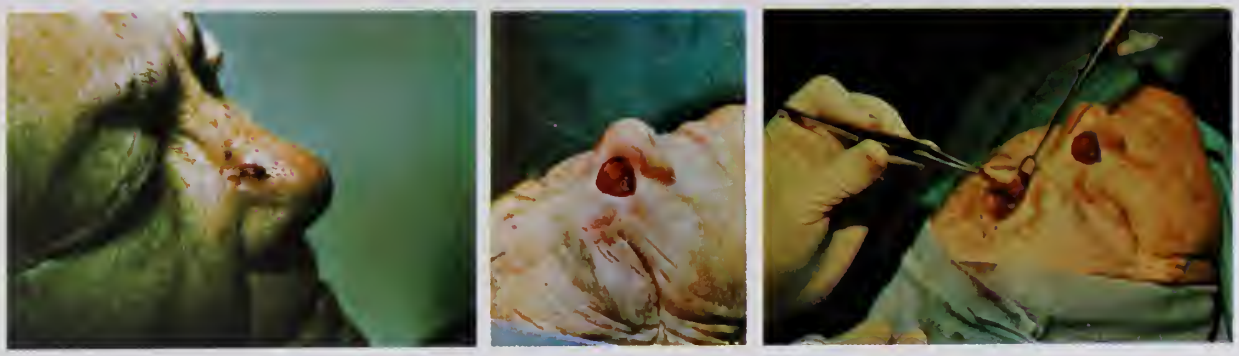


FIGURE 5

A. Recurrent basal cell of mid-lateral nose.

B. Defect following excision and outline of mid-forehead island flap.

C. Flap elevated from bed with attached vascular pedicle.



D. Flap after being pulled through subcutaneous tunnel and filling defect.

E. One week postoperative.

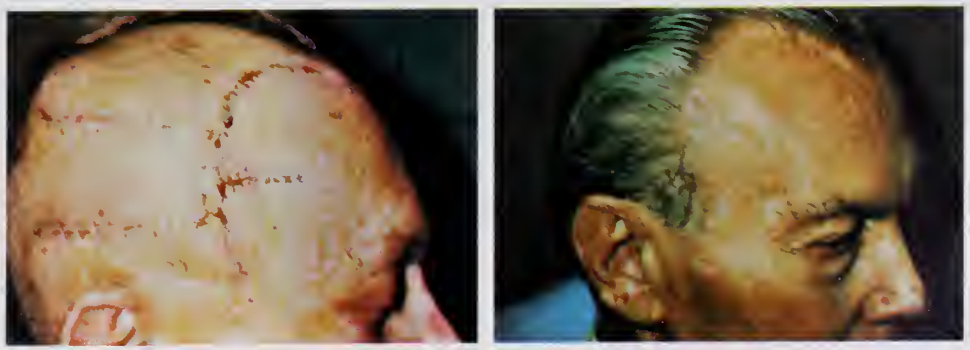
F. Postoperative results.



FIGURE 6

A. Example of combining rotational and advancement flap to cover large lateral forehead defect, maintaining normal hairline.

B. Six month postoperative results.



New Directions in Facial Plastic Surgery

Robert L. Simons, M.D.

Abstract: Facial aesthetic surgery has grown in both interest and demand. Surgeon and patient alike expect improved appearance with less surgical stigmata. Increased emphasis on a conservative approach to rhinoplasty and a better understanding of the patient's total facial needs have led to improved operative results. The advent of office or ambulatory surgical units now provides an economic, efficient and effective alternative to hospitalization for the care of the facial plastic patient.

How do you correct facial disharmony without changing facial character? How does one feel and look younger without exhibiting surgical scars? How can we provide the facial cosmetic patient with a more comfortable and predictable operative experience?

These are just a few of the questions now being considered and answered by the surgeon specializing in facial plastic surgery.

Rhinoplasty has long been the fountainhead of cosmetic surgical procedures. It remains today the most demanding and exciting operation in the repertoire of the aesthetic surgeon. Prominence of position on the face, concern about function as well as cosmesis, and a lack of protective covering for iatrogenically induced irregularities or the mere vagaries of healing combine to create the constant challenge in nasal surgery.

Along with improved surgical technique, public sophistication and expectations regarding rhinoplasty have grown measurably in the past decade. No longer is there enthusiasm for "a great-looking nose job." Former demand for the highly sculpted, pert, retrousse nose has given way to a desire for a more natural, less-operated nasal appearance. Throughout the country, present day teaching stresses the need for conservatism and flexibility. Often heard is the dictum, "In Rhinoplasty, we do a little to achieve a lot."

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Conservative Rhinoplasty

The best nasal surgery is performed by the conservative, yet flexible surgeon. A man who realizes that rhinoplasty involves millimeters of change and has the technical versatility to tailor the operation to the individual patient.

Surgical indiscretions and excesses often go unappreciated in the immediate postoperative period. The nature of healing of the nasal soft tissues often requires one to two years for the rhinoplasty to finalize in form; therefore, long term followup is essential in evaluating success of a procedure.

Though the operation is generally performed through internal incisions, most of the surgery can be visualized. With the aid of head illumination and adequate undermining of tissues, only the lateral osteotomies truly remain hidden from view. Marginal incisions with delivery of the alar cartilages help to insure symmetry in modeling of the nasal lobule.

Almost every rhinoplasty involves uncovering the nasal dorsum, shortening the nose, refining the nasal tip, lowering the cartilaginous and bony hump, and narrowing the nose.

To limit the variabilities in the operation, we frequently set the profile line by shortening the nose and proceeding with the tip surgery prior to hump removal. This is not an operation, however, that lends itself to "cookbook comfort" or conformity of procedure.

Large or deviated noses require primary attention to hump reduction and management of the underlying twisted septum. In most cases, the deviated nasal septum and external nasal deformity can be corrected during the same procedure. The rhinoplastic surgeon must be fully familiar with the septum and its supportive and functional value to the nose. Too frequently, poor septal surgery leads directly to post rhinoplasty deformity or persistent nasal obstruction.

One may categorize rhinoplasty complications in terms of omissions or commissions. Certainly the more grievous error is the one of excessive excision or over-operating. The best rhinoplasty is the one that frequently goes unnoticed.

Total Facial Analysis

One of the ways to avoid excessive nasal surgery is to carefully evaluate the patient's needs. Since the nose is beautiful only when it does not stand apart from the rest of the face, the surgeon must consider the other facial bony and soft tissue contours, such as the eyes, lips, forehead and chin. Realization of true facial beauty lies in the dynamic harmony between component parts!

To establish this harmonious relationship, the surgeon must frequently go beyond the sole performance of a rhinoplasty. He must concern himself with dentition, the relative position of maxilla to mandible, the aging process of the skin, and the proper use of makeup and hair styling. Though not necessarily practicing all disciplines, the complete rhinoplastic surgeon is aware and knowledgeable about the work of the orthodontist, the oral surgeon, the prothodontist, the facial cosmetic surgeon and the cosmetologist.

On profile, the nose, chin, lips and forehead are the most striking aspects of the face. When associated with either a sloping forehead or a recessed chin, the nose becomes unduly prominent. With the weak combination of a recessed chin and forehead, even a well proportioned nose cannot save that face from appearing inferior.

The art of rhinoplasty lies in camouflaging facial weaknesses, creating an image of a different look without labeling the patient as a "nose job." Short noses with receding chins and long noses with protruding chins are not harmoniously attractive, but rather accentuate the negative aspects of the face. One can distract attention from a protruding chin by judiciously shortening the nose and, conversely, offset a short nose by augmenting a weak chin (Figs. 1, 2).

Adjunctive Aids in Facial Rejuvenation

Among candidates for rhinoplasty we have found approximately 25% in need of chin augmentation. This combination of nasal deformity and retrognathia or microgenia often represents a developmental relationship based upon nasal injury and subsequent airway obstruction sustained during infancy.

Other candidates for augmentation mentoplasty include the aging patient with the short hyomental line resulting primarily from sagging of the cervical soft tissues and the younger individual with the functional Class II malocclusion who does not wish orthodontia. In the latter case, a chin implant provides soft tissue bulk, allowing for a more aesthetic lip closure.

Consideration of adjunctive measures is even more important in terms of the frontal appearance of the rhinoplasty patient. In direct confrontation, the eyes and general facial contour are noted prior to the nose. A patient with attractive eyes set in an oval face with strong, complimentary features of the upper, middle and lower thirds of the face is generally considered attractive. Proper attention to hair styling, makeup, appearance of the eyes and dental alignment can help the patient approach these ideals of beauty.

When cosmetics fail to hide wrinkles or when their application becomes increasingly difficult, the patient may first consider the need for some form of rhytidectomy.

It is well recognized that a modified rhinoplasty or mere shortening of the nose along with the face lift will enhance the total effect of facial rejuvenation in the elderly patient. Conversely, the older rhinoplasty patient often benefits from revitalization of the eyes through blepharoplasty or brow lift procedure. Deep nasolabial folds that add to nasal length may be alleviated with rhytidoplasty.

The rhinoplasty may be performed in conjunction with the blepharoplasty, brow lift or face lift. Variations in experience, operative setup and technical skills dictate whether the procedures should be done together or staged on separate days.

Office Surgery

A major innovation in the care of patients seeking facial rejuvenation is the advent of office surgery. Born of economic considerations, ambulatory surgical facilities are now providing a convenient, efficient and effective alternative to hospitalization for a variety of surgical procedures.

The rising costs of hospital care, coupled with the increasing difficulties in scheduling surgical cases has induced many surgeons to establish their own, or to utilize an already existing outpatient facility. With increasing experience, it has become apparent that office surgery significantly reduces costs, saves patient and doctor time, and offers safe and efficient health care.

Proper planning of the surgical area, especially in an office also involved with medical care, is essential for an efficient operation. For reasons of sterility, as well as safety, the surgery unit must be a self contained and completely equipped entity. Yet, it should not be so far removed from the main pool of personnel that any emergency cannot be readily recognized or answered (Figs. 3, 4).

Appropriate preparation for response to any possible emergency is perhaps the most important consideration in an office operating room setup. Fortunately, the occurrence is rare, but the ability to respond to an emergency as one might in the hospital is the basis for office surgery credibility.

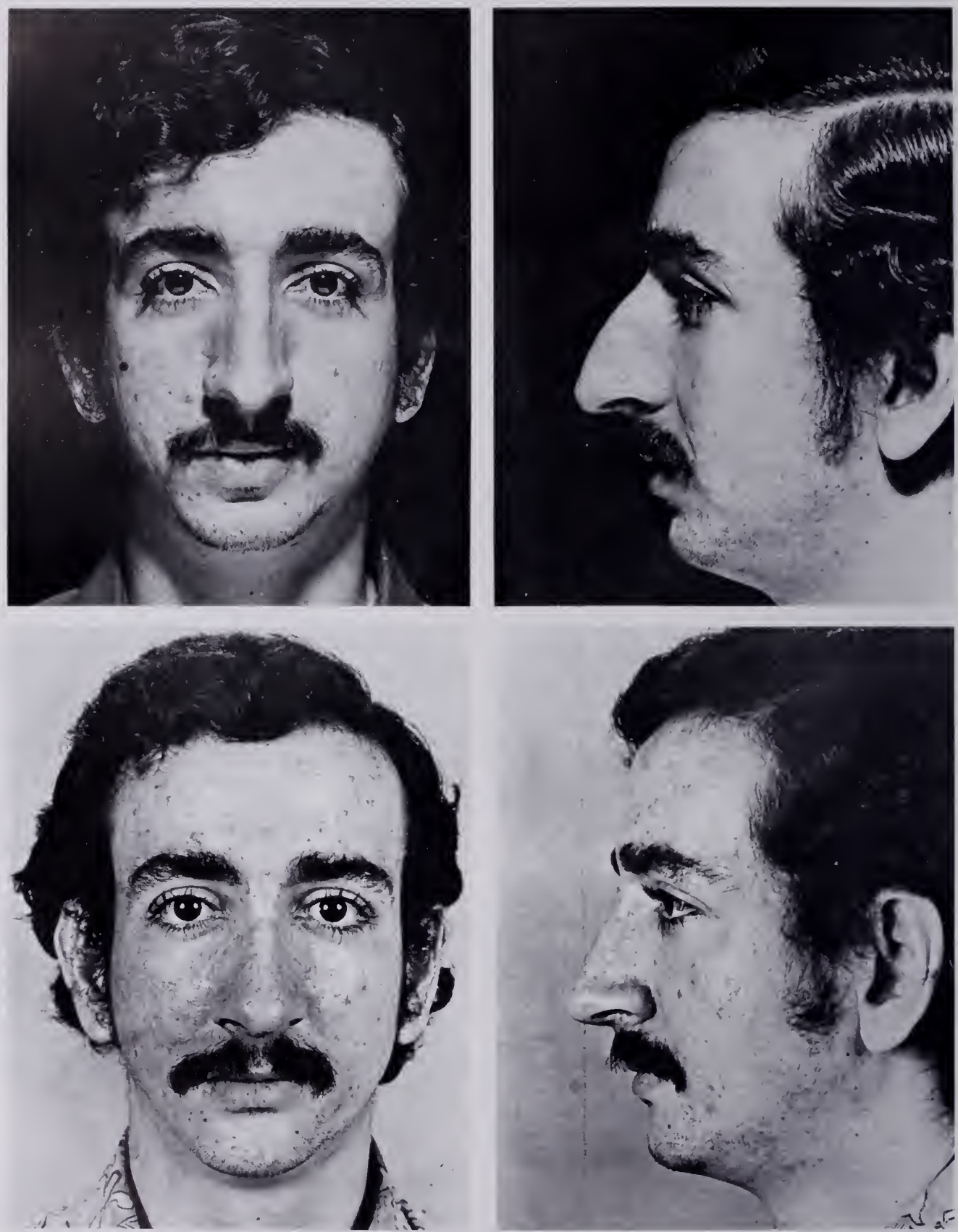


Fig. 1. — A,B,C,D. Pre and postoperative frontal and lateral views. Note conservative rhinoplasty with chin augmentation.



Fig. 2. — A,B,C,D. Pre and postoperative frontal and lateral views. Use of columellar batten in rhinoplasty along with mentoplasty.

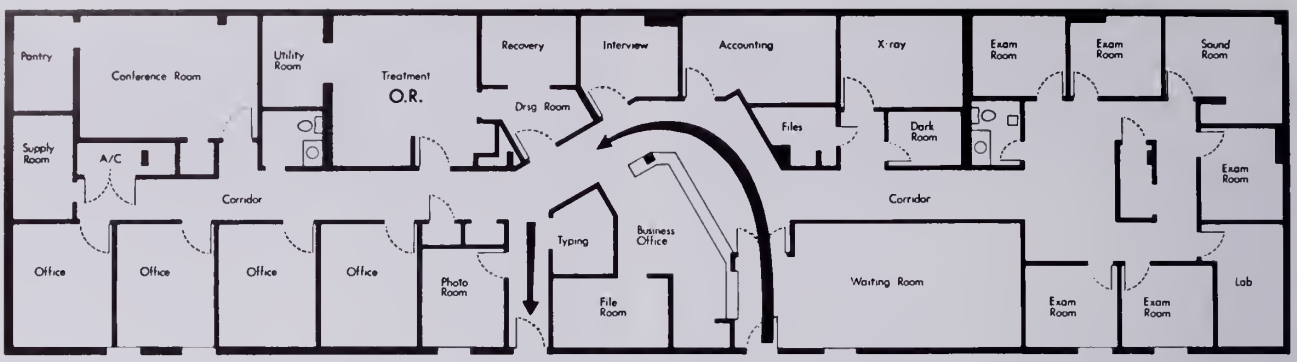


Fig. 3. — Office diagram with surgical flow directed away from routine office care.

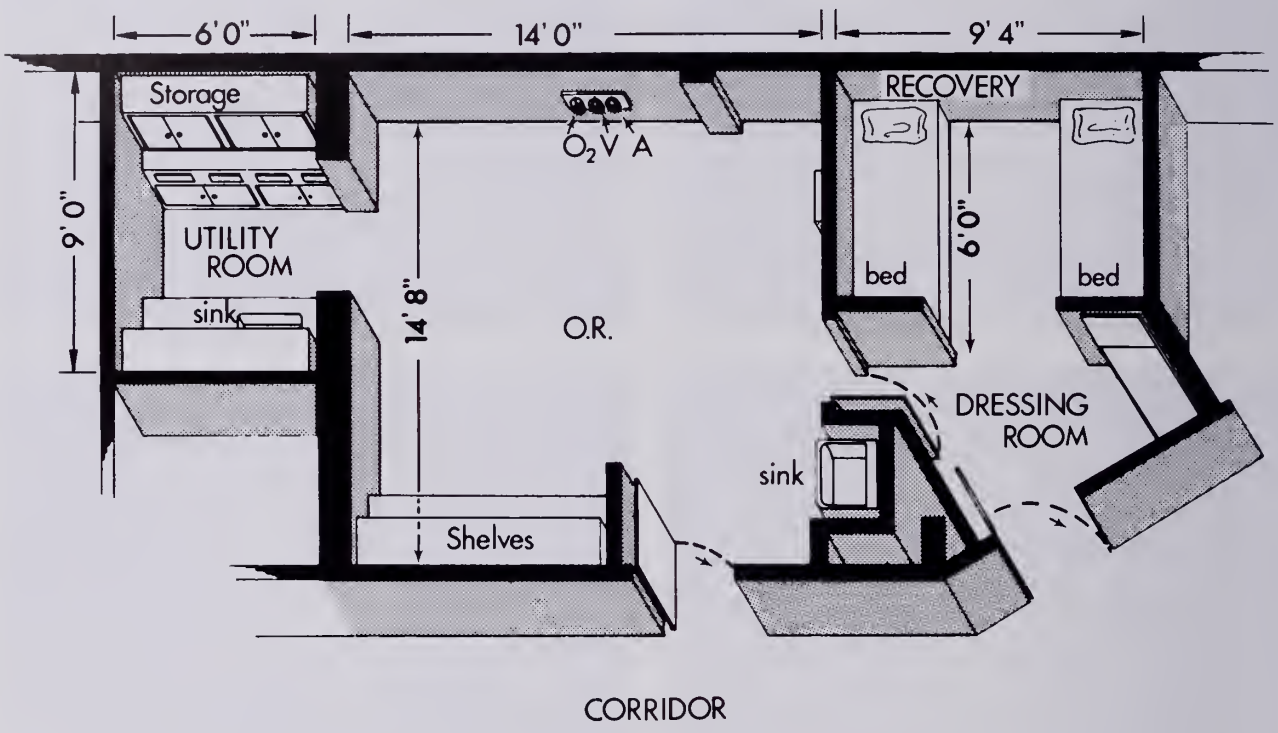


Fig. 4. — Dimensions of surgery facility.

Modern monitoring and resuscitation equipment, along with appropriate IV solutions and drugs, must be available. Ideally, all office personnel should be familiar with these facilities and retrained periodically in cardiopulmonary resuscitative (CPR) techniques. In our experience, the biggest single factor providing comfort and security to patient and surgeon alike has been the addition of a well-trained anesthetist to our regular operating room team.

The office surgery patient is thoroughly counseled preoperatively about what he may expect and what is expected of him. Procedures such as rhinoplasty, blepharoplasty, face lift, and otoplasty require recent medical clearance including blood count, urinalysis, bleeding and clotting times, chest x-ray, and EKG.

Though office surgery can certainly decrease the amount of paper work required by most hospitals, it is important that the office record contain a complete

preoperative history and physical, consent forms, appropriate lab work, any applicable pathology reports, as well as the dictated operative report and following postoperative notes. Office records, albeit abbreviated, must not reflect a casual or haphazard approach to the patient's surgical care. The office O.R. is not a refuge for the poorly trained or improperly motivated surgeon.

Since the patient leaves the office several hours following surgery, efforts are made not to use drugs of a highly sedative or long-acting nature. All patients have an intravenous running and are attached to cardiac monitoring equipment. Drugs are titrated through the IV, and are generally agents such as Demerol, Valium, and Innovar with readily available antagonists.

Operative equipment, along with trained personnel, does not differ from what one would expect in the hospital operating room. Electrosurgical cautery units, central suction, autoclaves, emergency lights, and proper gowns and drapes are just a few of the items that must be a part of the surgical setup.

Following surgery, the patient is returned to the recovery area where again the preplanned availability of a suction and oxygen source, bedside rails, and a buzzer for the patient to communicate with the office is important for the maintenance of proper safety standards.

The provision of such a surgical unit requires space and capital. For those men specializing in facial plastic surgery, it is a new direction that one cannot afford to ignore. Office surgery provides a new, more expedient, comfortable delivery of health care, while directly responding to the growing concern among the public and government for improved cost containment of medical services.

Our experience, like that of many others, shows that patients often profit both physically and emotionally from choosing office surgery over hospitalization. The patient benefits from the familiarity of surroundings and staff, from the proximity of the surgeon in the immediate pre- and postoperative period, as well as from the sense of well being while recuperating at home. The surgeon's advantages include better utilization of his time, a regular surgical staff attuned to his needs, and a more flexible facility to meet his need for the patient's facial rejuvenation.

Today, interest and enthusiasm regarding facial plastic surgery is burgeoning. Awareness of improved surgical techniques and facilities will help to insure tomorrow's continued growth and satisfaction for both the surgeon and his patient.

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The Ten Commandments contain 297 words. The Bill of Rights is stated in 463 words. Lincoln's Gettysburg Address contains 266 words. A recent federal directive to regulate the price of cabbage contains 26,911 words.

Evaluation of the Cervical Mass

William H. Davis, M.D., F.A.C.S.

Abstract: The adult cervical mass continues to be a challenge to the primary physician and to the specialist. While proper evaluation has been stressed for a decade since Hayes Martin, the premature cervical biopsy continues to be a serious surgical misadventure, potentially decreasing survival up to 50%. This short review seeks to emphasize again the appropriate workup.

The cervical mass remains an enigmatic and fascinating medical problem. It has defied scientific solution in an age of golden progress. The crusading effort of Hayes Martin of the last decade has failed to change the continued mismanagement of the cervical mass. The most common serious error in the management of the cervical mass is the premature surgical biopsy. The premature surgical biopsy fails to meet the standard of good surgical care. MacComb[1] reported 77% of referred patients to M.D. Anderson Hospital had a prior neck biopsy before being referred. Despite the numerous medical articles reviewing this error, it still eludes dissemination to the primary physician, general surgeon and others. It is the gravity of this error in medical judgment that this paper seeks to emphasize.

In the vast spectrum of the cervical mass, the adult with the solitary, asymptomatic mass represents the most challenging problem. The differential diagnosis includes congenital, developmental, and inflammatory masses. Congenital problems such as the thyroglossal duct cyst and the brachial cleft cyst have characteristic locations and physical findings. Likewise, primary tumors of the neck such as from the parotid gland and the thyroid gland should have a high index of suspicion on the physical examination. The inflammatory masses are common to all ages. The inflammatory mass is the most common cervical mass encountered by the primary physician. Again, classical characteristics are usually accompanied with inflammation. It is clearly reasonable to treat the patient who presents with a neck mass of short duration with antibiotics; however, deception may be encountered as lymphomas and metastatic squamous cell carcinomas have been seen to temporarily regress in size with heat and antibiotics. Here, clinical judgment is critical.

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Case Example

The following case is offered to illustrate the surgical misjudgment of the premature biopsy. J.V. is a 71-year-old white male who was referred simultaneously on November 8, 1977, by a radiologist and a medical oncologist. J.V. presented with right posterior triangle neck nodes in mid-1977. An inflammatory process was suspected and so treated with antibiotics by the primary physician. This failed to help and the primary physician referred the patient to a general surgeon who performed a biopsy in July 1977 without the benefit of an appropriate head and neck examination. The biopsy showed a malignant epithelial tumor most consistent with carcinoma of the breast. The patient was then referred to a medical oncologist who treated this as though these were metastatic nodes from an infraclavicular source. Having failed to respond to chemotherapy in September and October 1977, the patient was referred to a radiotherapist who entertained the diagnosis of a nasopharyngeal carcinoma. Thus, this patient was initially seen on consultation on November 8, 1977. The office examination revealed a large nasopharyngeal lesion and multiple large right cervical lymph nodes. Hospital biopsy revealed squamous cell carcinoma in the nasopharynx. Following completion of full course therapy on January 27, 1978, with a linear accelerator, a one centimeter mass was noted to persist in the incision site in the right neck. Persistent nasopharyngeal disease was diagnosed by biopsy on May 12, 1978. The patient is currently receiving chemotherapy. We will discuss the sequence of events as this case embodies the usual errors in handling this type of problem.

Protocol for Workup

The problem in question is the persistent solitary asymptomatic neck mass in the adult. As previously mentioned, the surgical biopsy should be the last step of the workup — not the first. In the adult, exclusive of benign thyroid disease, the most common neck mass represents *malignant* neoplastic disease. Most malignant tumors of the neck are metastatic. Most metastatic tumors originate from primary sites above the clavicle. This knowledge is common and is well documented in the medical literature. Armed with these well known facts, the premature surgical biopsy confirms only the working diagnosis. Thus, no new knowledge is gained. Time is lost. In our example case, some three months of delay were encountered.

The first step in the workup of the persistent cervical mass is a thorough history and physical examination including a complete head and neck examination. This generally entails an otolaryngologic consultation. Our example case shows that an office consultation revealed the primary site. Its large size would indicate that it could have also been visualized months earlier. If the office examination is inadequate or fails to reveal the primary site, then the patient should be admitted to the hospital for panendoscopy (nasopharyngoscopy, direct laryngoscopy, esophagoscopy, and bronchoscopy). Appropriate preoperative studies must be ordered and certainly include a chest x-ray. The panendoscopy may be done under local or general anesthesia. Since most of the malignant neck masses originate from sites above the clavicle, the panendoscopy is the most expeditious step towards the definitive diagnosis. However, if the primary site is not found then no biopsy is taken. Blind biopsies would give distortions on the x-ray workup. At this point, a workup is done which would include upper and lower GI series, IVP, thyroid and salivary scans, sialograms, laminograms of the lungs and sinuses, soft tissue lateral of the neck, and a contrast laryngogram. At this time, if no primary site is found, blind biopsies are taken from the nasopharynx, tonsils, base of tongue, pyriform fossae, and any suspicious sites. The blind biopsy has eliminated the nasopharynx as the number one source of the unknown primary site.

Should the primary site be found on panendoscopy, then the appropriate therapy may be instituted. If the primary site cannot be found, then the management of the neck mass turns to the surgical biopsy. Needle aspiration is certainly appropriate. When open biopsy is done, frozen section is obtained and a radical neck dissection may be done at this same setting, if indicated.

Case Against the Premature Biopsy

MacComb[1] has restated the case against the premature biopsy of the cervical mass. The principles are unchanged as those advocated by Hayes Martin. (1) Edema resulting from the surgical procedure makes the radiological diagnosis difficult. (2) Premature biopsy delays the search for the primary site. (3) The primary site is the most important item to be considered. Appropriate therapy cannot be instituted until the correct diagnosis is made. The example case had a 4 month delay in beginning the appropriate therapy. An unnecessary delay in instituting therapy could have an influence on the cure rate. (4) The premature biopsy prevents or precludes a clean radical neck dissection. (5) The biopsy incision is often placed so as to interfere with the radical neck incision. When the incision site in the skin is incorporated into the radical neck specimen, closure is often interfered with requiring a regional skin flap. (6) Recurrence or persistent disease of the neck is related to the incision site. MacComb offers the explanation that disturbed circulation in the biopsy site prepares an excellent breeding ground for renewed growth of immature cancer cells. Again, the recurrence or persistence of disease in the neck influences the cure rate. In our case example, the cervical nodes had an excellent response to radiotherapy except at the surgical biopsy site where persistent disease is noted.

Conclusion

A protocol has been offered for the workup and management of the solitary asymptomatic adult neck mass. It should be remembered that the head and neck examination is the most important facet of this workup. The otolaryngologist is the most qualified person for the head and neck examination.

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The great things about computers is that there are just as many mistakes as ever, but now they are nobody's fault.

Squamous Cell Carcinoma of the Skin Metastatic to Parotid Nodes

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Abstract: Squamous cell carcinoma of the face may metastasize to the parotid lymph nodes. There may be a long interval between the excision and the metastasis. The best survival is obtained by surgery followed by radiation.

Metastatic squamous cell carcinoma from the skin of the face and neck to the parotid lymph nodes is uncommon.[1] A preauricular mass may often be interpreted as a primary parotid malignancy, and the history of previous treatment of a skin cancer overlooked. Very few articles deal specifically with this problem, and most series include malignant melanoma.[1-6] The purpose of this report is to present our experience at the University of Florida with metastatic squamous cell carcinoma of the face to the parotid nodes and to recommend treatment.

The parotid lymph nodes develop embryologically before the parotid gland and are divided into two subgroups: the paraglandular nodes and the intraglandular nodes. An average of 20-30 nodes is said to be present.[1] The paraglandular nodes are predominantly in the preauricular area, along the superficial temporal vessels. These nodes receive drainage from the lateral and frontal aspects of the scalp, ear, lateral half of the lower lid, upper lid, and root of the nose. The paraglandular nodes along the tail of the parotid receive afferents from the preauricular group, buccal mucous membrane, cheek, parotid, pinna, and intraglandular nodes.[6]

The intraglandular nodes are located along the posterior facial vein between the superficial and deep portions of the gland and are both superficial and deep to the facial nerve.[6] Afferent drainage is from the lateral and frontal aspects of the scalp, lateral aspects of the lids, lacrimal gland, conjunctiva, external auditory canal, parotid gland, and paraglandular nodes.[6] Both the para- and intraglandular lymph nodes may be involved by metastatic squamous cell carcinoma.

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Methods and Materials

The records of 22 patients treated at the University of Florida for squamous cell carcinoma of the skin metastatic to parotid nodes between January 1966 and March 1977 were studied. One patient given only palliative therapy and another with adenoid pseudoglandular carcinoma were excluded from the study. The patients consisted of 17 males and three females with ages ranging between 46 and 85 years. The histology of the parotid nodes was squamous cell in 18 patients, undifferentiated carcinoma in one, and anaplastic carcinoma in another. All patients had at least one squamous cell of the skin excised from the same site of the preauricular metastasis.

Figure 1 shows the sites of the previously treated skin lesions. The time interval from the excision of the skin lesion to the presentation of the preauricular mass range from two weeks to five years with most appearing within the first year. The size of the preauricular mass ranges between one and six centimeters. The facial nerves involved preoperatively in three patients: two had complete facial nerve involvement and a third had only the lower branches involved. Preoperatively the ipsilateral neck was thought to be positive in eight patients. Radical neck dissection was done in 10 patients; in nine it was performed as part of the initial procedure and in the other it was performed shortly after a superficial parotidectomy. No patient has subsequently developed a mucosal head and neck primary.

Treatment

The initial mode of treatment for the preauricular metastasis was as follows: Two patients had irradiation

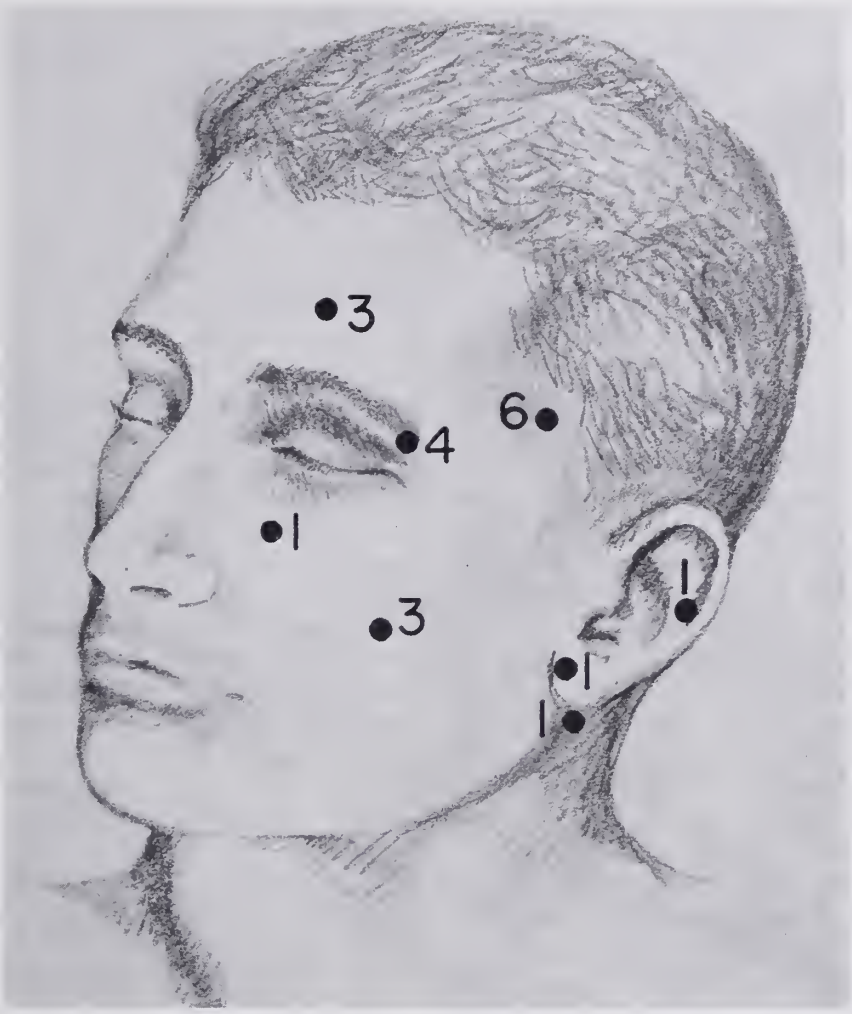


Fig. 1. — Site of Previous Skin Cancer.

therapy alone, eight had surgery alone, and 10 were given combined treatment. In the group treated with surgery alone one patient had a simple excision of the preauricular mass, one had only a radical neck dissection, three had superficial parotidectomy alone, and the remaining three had superficial parotidectomy with an incontinuity radical neck dissection. In the combined therapy group five patients had superficial parotidectomy alone, three had a superficial parotidectomy followed by radical neck dissection. The facial nerve was sacrificed only if involved with tumor. The surgery was followed by 6000-8000 rads to the parotid area and 5000-6000 rads to all or part of the ipsilateral neck.

Two patients were treated by radiation alone for cure: one received 6000 rads in 5½ weeks to the parotid and upper neck area only, and the other received 7000 rads in seven weeks to the parotid area and 5000 rads to the entire ipsilateral neck.

Results

Six of the eight patients treated with surgery alone failed in the parotid area; two also had ipsilateral neck failure. Salvage was attempted on two patients; only one was salvaged by combined surgery and radiation. Five patients eventually died with uncontrolled disease above the clavicle, two with concomitant distant metastasis. One additional patient died of distant metastasis with disease controlled above the clavicle. The absolute survival rate in the surgery alone group is two of eight or 25%.

Of the 10 patients treated with surgery followed by postoperative radiation therapy, one failed in the parotid area and another in the low neck. The former had a superficial parotidectomy and radical neck dissection; he did not complete his planned radiation therapy. He received only 4500 rads to the parotid and 3600 rads to the neck, which had had positive nodes in the pathologic

specimen. The second patient failed in the low neck after being treated by a total parotidectomy, radical neck dissection, and postoperative irradiation consisting of 6500 rads to the parotid and 500 rads to the lower neck. The pathological specimen showed 15/50 nodes positive. The absolute survival is 80% with followup ranging from 18-72 months.

Of the two patients treated with radiation therapy alone, one failed from the original skin primary in the temple which had spread to the dura, and could not be salvaged. One is free of disease at 31 months. The management of the neck was as follows: nine patients had radical neck dissection. Six were clinically positive and all six were pathologically positive. Three were clinically negative preoperatively and the pathologic specimens were all negative. The neck in two patients was clinically positive and treated by radiation therapy alone; they were both without evidence of any disease. Three patients failed in the neck. Two patients with negative necks had no treatment until neck metastasis occurred; salvage attempts with both surgery and radiation therapy proved unsuccessful, and both died from distant metastasis. Patients with clinically negative necks treated with radiation therapy alone have not developed neck metastasis.

Three patients were known to have facial nerve involvement preoperatively. The nerve was totally sacrificed in two and partially sacrificed in five patients when it was noted at surgery that the nerve was either involved or in close proximity to the tumor. Analysis of the seven patients with nerve involvement shows that two had surgery alone and five had surgery and irradiation. One of seven patients had a parotid recurrence, and he was one of two treated with surgery alone.

The morbidity from postoperative irradiation was minimal with five patients developing a mild to moderate sore throat. One patient required a myringotomy for serous otitis media.

Discussion

Metastatic squamous cell carcinoma from the skin of the face and scalp is uncommon; however, when it occurs it usually presents as a painless preauricular mass. The facial nerve was involved preoperatively in only 15% of our patients, in contrast to a 35% postoperative facial nerve morbidity, ranging from complete paralysis to involvement of only one branch.

Surgery alone resulted in a 75% parotid bed/ipsilateral neck recurrence rate, and a subsequent survival rate of 25%. This also appears to be borne out in other series.[1,3,5] The high recurrence rate can be explained by the work of Graham which showed that virtually all the parotid nodes lie lateral to the posterior facial vein.[6] The facial nerve may pass between the vessels, lie lateral to the vessels, or be separated from the vessels by parotid tissue. Based on this anatomical evidence, superficial parotidectomy as generally performed (i.e., following the nerve) is usually inadequate and may leave behind some of the parotid tissue superficial to the vessels.

Surgery coupled with postoperative irradiation resulted in a 20% parotid bed/ipsilateral neck failure rate. It would appear that the addition of postoperative irradiation sterilizes small residual disease that may be present. A minimum dose of 6000 rads is recommended to areas originally positive, with higher doses if gross residual is suspected. Radiation therapy alone in the treatment of this disease should be reserved for very small nodes or for use where surgery is contraindicated.

Forty percent of our patients had clinically positive necks when initially seen. A radical neck dissection is recommended, followed by 6000 rads of postoperative irradiation if the neck specimen is positive. The incidence of failure in an N_0 neck after 5000 rads of radiation is very low. Neck dissection is omitted in these cases, and irradiation to the entire neck is advised.

Summary

1. The first order of nodes from the skin of the face, scalp, and neck is the parotid nodes.

2. There may be a long interval between prior treatment of a squamous cell carcinoma of the skin and the appearance of the metastatic parotid node.

3. Superficial parotidectomy is usually inadequate for complete removal of the lymph nodes, since the nodes lie lateral to the posterior facial vein and not the facial nerve.

4. Surgery followed by postoperative radiation therapy appears to give better survival that either modality alone. The facial nerve should be totally or partly sacrificed only if grossly involved.

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Laryngotracheal Trauma

Diagnosis and Treatment

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Abstract: The widespread use of automobiles and motor-powered recreational vehicles has given rise to increased numbers of severe laryngotracheal injuries. The growing use of advances in respiratory resuscitation including assisted ventilation with cuffed tubes has also produced growing numbers of severe laryngotracheal complications. Modern diagnostic techniques including fiberoptic endoscopy laryngograms, retrograde tracheograms, polytomography and xeroradiography have facilitated the early recognition of these injuries. Despite early diagnosis and skillful surgical management, serious voice and airway difficulties still develop in some patients. Therefore, a heightened awareness by emergency room teams, anesthesiologists, pulmonary physicians, and laryngologists is necessary to insure the diagnosis and proper early management of laryngotracheal trauma.

Awareness of the possibility of external or internal trauma to the laryngotracheal complex is essential to all physicians dealing with trauma and resuscitation. The biodynamics of blunt injury to the larynx and trachea after automobile collisions or following the use of recreational vehicles have been studied.[1] Briefly, the victim and vehicle are moving at the same rate of speed prior to collision. After impact and momentary deceleration, inertial forces bring the victim forward toward the steering wheel or dashboard. In most cases, the mandible protects the neck from injury. When the neck is in hyperextension, the vulnerable anterior cervical structures including the larynx and upper trachea can be crushed against the unyielding cervical vertebrae. Similarly, drivers of minibikes, motorcycles, etc., have injured their necks after unexpected contact with nonyielding environmental hazards such as cables, tree branches and fences.[2]

Advances in respiratory care have produced more survivors after prolonged ventilatory assistance.[3] Obstruction of the upper airway, especially subglottic stenosis and tracheal injury, are more likely to occur following prolonged ventilatory assistance. Clinical awareness of the occurrence of stenosis and malacia has increased and more patients benefit from early diagnosis and treatment. The incidence of complications is difficult to establish because of such variables as patient population, duration, and methods of ventilatory assistance. Estimates of complications range from 10% to 20% of cases in various respiratory units. These complications are more common in especially vulnerable patients with severe respiratory failure and associated systemic illnesses. The pathogenesis of these internal laryngotracheal injuries is related to the mechanical trauma from endotracheal intubation and inflated cuffs.

Diagnostic Techniques

External Traums: A careful review of the history will offer valuable clues as to the probable location and extent of laryngotracheal injury. As mentioned, the blunt injury resulting from an automobile collision commonly involves the victim striking a padded dashboard with his extended neck. Usually this results in an oblique fracture of the thyroid cartilage. After mishaps with minibikes, etc., adolescents and prepubertal youngsters have a tendency to laryngotracheal disruption following injuries low in the neck with unnoticed cables, wires, or tree branches (Fig. 1).[2] Physical signs after blunt injuries to the neck include abrasions, contusions, subcutaneous emphysema, and loss of palpable normal laryngeal landmarks. Obviously, the great danger in these types of injuries is the fact that they are of a closed nature and not

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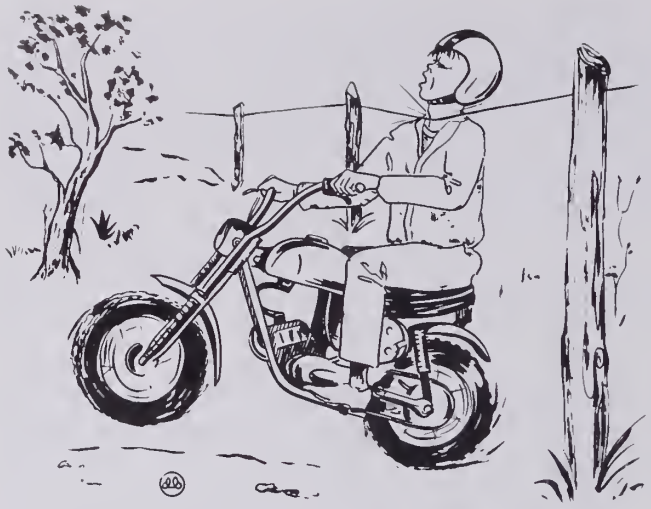


Fig. 1. — Minibike rider striking occult cable with neck.

as obvious as the laryngotracheal damage from penetrating objects such as missiles, projectiles, and knives. Symptoms can be grouped conveniently under the following headings. Problems with the airway may be characterized by inspiratory stridor, which is usually high pitched, suprasternal retractions, a nonproductive cough, hemoptysis, or expiratory wheezing. Voice abnormalities include hoarseness, aphonia, odynophasia, muffled voice, and whispering. Disturbances of deglutition can include dysphagia, drooling and rarely, hematemesis. Initial physical exam should exclude damage to contiguous structures such as the cervical vertebrae, to major vascular structures, and to intrathoracic structures. Loss of thyroid or cricoid prominence and fullness of the neck can be palpated and indirect laryngoscopy may demonstrate tears in the pharynx, displacement of supraglottic or glottic structures, paralyzed vocal cords, etc. X-ray studies should include A-P and lateral soft tissues of the neck, chest x-ray, cervical esophagogram, and arteriograms when indicated. The most immediate concern is to establish an adequate airway by peroral intubation, masked ventilation, or immediate tracheotomy. After the patient is sufficiently stabilized, the workup should include a laryngogram or a lateral xeroradiograph and possibly a retrograde tracheogram to evaluate the laryngotracheal pathology. Prior to the exploration, a panendoscopic study is required. With this accurate assessment of the injury the surgeon can then select the appropriate means to correct whatever pathology is present.

Internal Trauma: The history of prolonged ventilatory assistance with cuffed endotracheal and tracheotomy tubes increases the possibility of laryngotracheal injury. Other factors such as severe systemic disease, episodes of hypotension, local contamination, and generalized sepsis must be considered. The lesions associated with endotracheal tubes can be located at the cord level or subglottically 2-3 cm below the level of the true cords (Fig. 2). Clinical symptoms will be similar to those described previously and will involve respiration, voice and deglutition. In particular, a nonproductive cough, dysphagia, hoarseness and/or inspiratory stridor with progressive air hunger are characteristic. These symptoms may appear immediately after decannulation or can be delayed as long as one to two months after extubation. Diagnostic tools include indirect laryngoscopy, endoscopy and various x-rays as previously described. Severe inspiratory stridor will require immediate reestablishment of an airway by endotracheal tube or tracheotomy prior to definitive repair.

Surgical Repair: After an accurate assessment of the location, type, and extent of the injury, open repair is usually required. After blunt external injury, open repair should be performed within a week following the injury. Fractures and dislocations at the laryngeal level are approached through a transverse cervical incision and usually require a median thyrotomy for direct inspection and realignment of the soft tissue and cartilage.[4] After suitable repositioning of fragments and direct suturing of mucosal tears, an internal stent is placed. The rehabilitation of paralyzed vocal cords should be deferred for one year post-injury because of the possibility of a spontaneous return of function. Laryngotracheal separation injuries such as reported with minibikes and other recreational vehicles will require cricotracheal anastomosis (Fig. 3).[2] This type of injury is especially difficult to manage because after the separation, the trachea retracts substernally and at the time of initial treatment the physician must be prepared to do an immediate tracheotomy. Again, internal stenting via median thyrotomy is required along with the cricotracheal anastomosis. Cases of subglottic and tracheal stenosis require elective open repair as definitive treatment. The approach to the repair of subglottic stenosis is similar to the approach in the acute external laryngeal injury; however, after the thyrotomy is completed, scar removal usually leaves a denuded area of cricoid or tracheal cartilage. This requires the introduction of an autogenous tissue graft such as a very thin split skin graft or a dermal graft. If there is severe damage to the cricoid cartilage, it may be necessary to replace the anterior arch of the cricoid with an autogenous graft of hyoid bone (Fig. 4)[5,6] This will restore the architecture of the cricoid ring. Cases of tracheal stenosis at the thoracic inlet will require a combined



Fig. 2. — Subglottic stenosis following intubation.

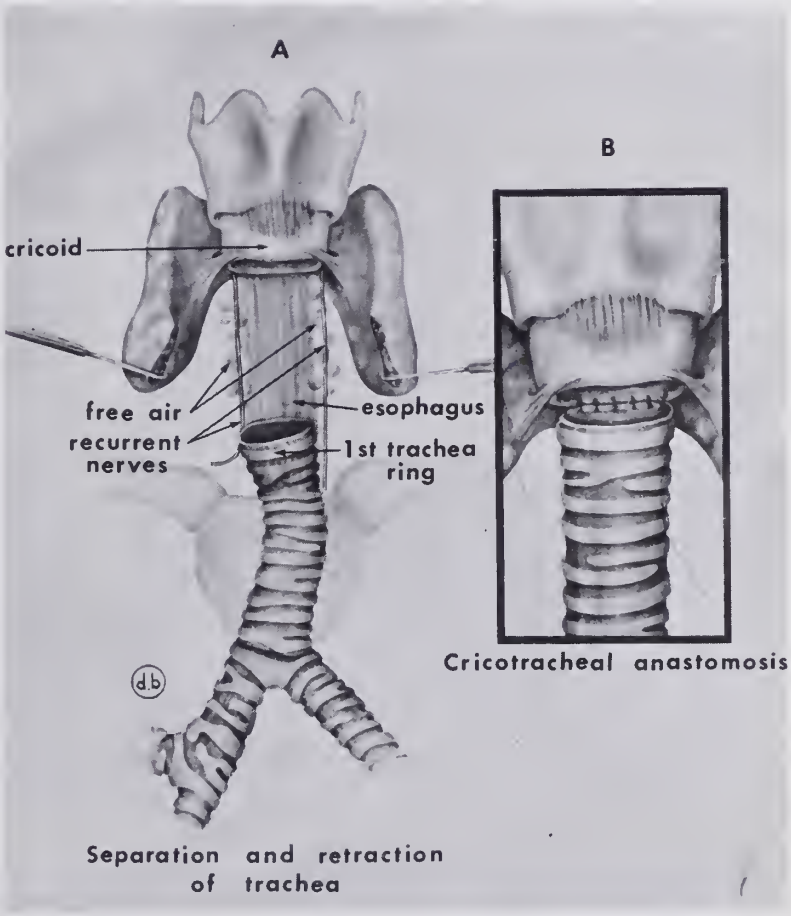


Fig. 3. — Laryngotracheal disruption and anastomosis. (Note the proximity of the recurrent laryngeal nerves.)

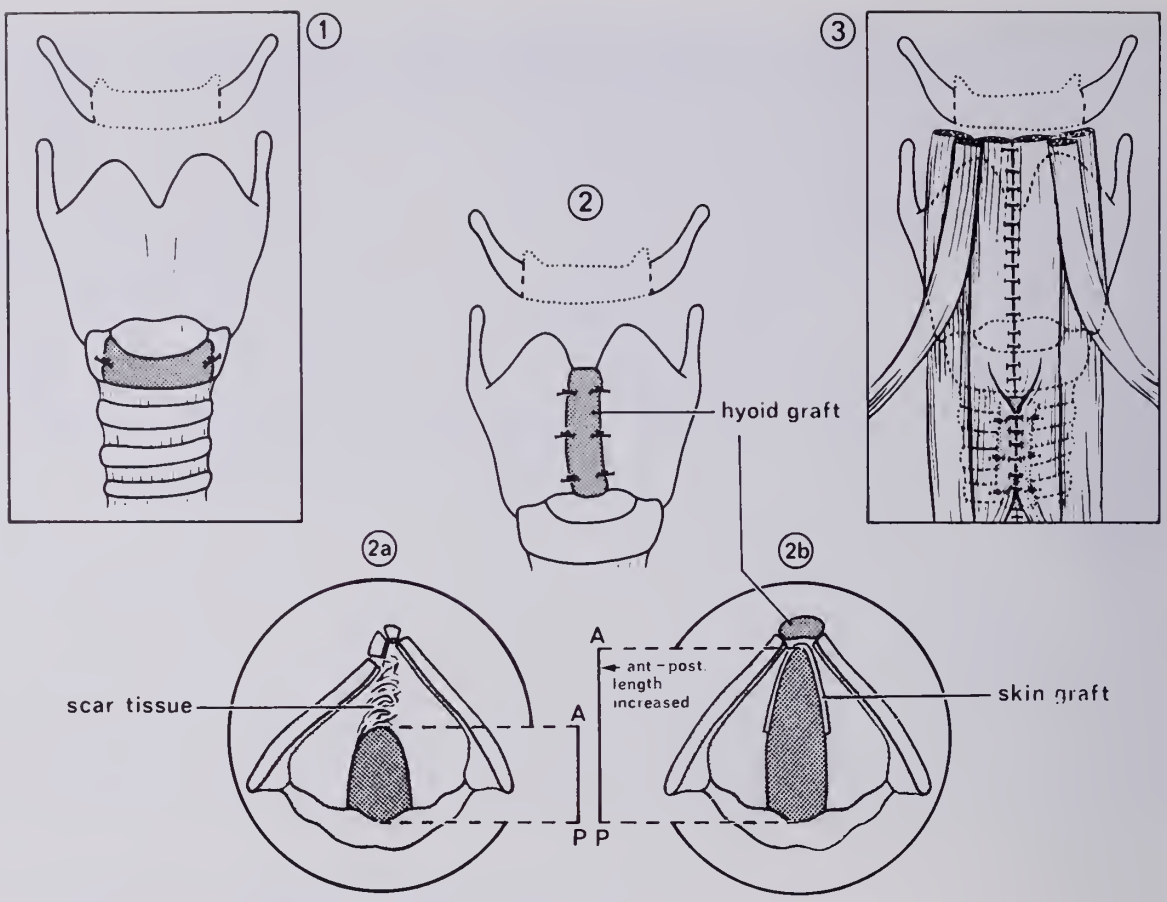


Fig. 4. — Variations in the use of the hyoid bone graft.

cervical and thoracic approach for repair.[3] The younger the patient, the greater tracheal mobilization is possible. Tracheal stenosis will require either sleeve resection or wedge resection of the affected area. Anterior tracheal wall defects may only require wedge resection retaining most of the tracheal architecture. Portions of the anterior tracheal wall can be replaced by approximating the strap muscles in the middle and a wedge of hyoid bone can be sandwiched in the strap muscles to add additional rigidity.[6] The best results in the surgical treatment of circumferential tracheal stenosis are obtained with end-to-end anastomosis. A critical factor is that the end-to-end anastomosis be tension free. Laryngeal release (dropping the larynx) is the key procedure when attempting a sleeve resection of a circumferential tracheal defect for direct end-to-end anastomosis. Flexing the head and neck during the tracheal anastomosis is also an important relaxing maneuver. The thoracic surgeon can obtain some additional freedom by various intrathoracic releases.

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Somebody figured it out — we have 35 million laws trying to enforce ten commandments. — Earl Wilson

Airway Intervention in Croup and Epiglottitis Update '78

Nicholas L. Schenck, M.D. and Barry S. Kronman, M.D.

Abstract: Nasotracheal intubation in croup and epiglottitis has become the *short* term airway intervention of choice. The patient must be managed in a larger hospital which can provide around-the-clock, trained personnel (doctors and nurses) in an intensive care unit. If intubation need be prolonged greater than 72 hours, tracheostomy should be considered to avoid the wellknown complications of long-term intubation.

In our Florida community hospitals which do not have 24-hour inhouse coverage by a physician (or anesthetist) trained in pediatric intubation, tracheostomy remains the safer alternative.

Times have changed, and the old adage that "You should do a tracheostomy when you first think about it," needs to be reexamined. The burgeoning interest of pediatricians, pulmonary specialists and anesthesiologists in the management of croup and epiglottitis forces surgeons to reevaluate their role in the care of infants with infectious airway obstruction.

A Century of Endotracheal Intubation

In the past 100 years endotracheal intubation systematically replaced tracheostomy for several important indications, most notably in neonatal airway intervention. In addition, for croup and epiglottitis it is becoming apparent that endotracheal intubation as a short-term substitute for tracheostomy, is quicker, safer, and carries a lower morbidity and mortality. Not unexpectedly, however, acceptance has been delayed by cautious laryngologists who treat the complications of intubation.[1-7]

Infectious Airway Obstruction in Children

A majority of upper airway obstruction in children is inflammatory in nature, and it is in these instances where endotracheal intubation has been efficaciously applied. This is in contrast to an actual *increasing* incidence of pediatric tracheostomy in central nervous system disorders, congenital anamolies, and upper airway trauma.[6] A detailed examination of croup and epiglottitis is beyond the scope of this paper, but suffice it to say that croup (laryngotracheal bronchitis) is an edematous viral infection of the airway below the true vocal cords, and responds over 95 percent of the time to medical management (humidification, steroids, racemic epinephrine). Epiglottitis (supraglottitis) is a bacterial infection of the larynx above the true vocal cords, involving the epiglottis and supraglottic larynx (i.e., supraglottic laryngitis). Tracheostomy has been the mainstay of treatment because of the real potential for abrupt airway obstruction. Initial medical management has been suggested,[9] but most authors feel that this is a dangerous course to tread.[10-12] For the purpose of our discussion, let us assume that airway intervention is necessary in most all cases of symptomatic epiglottitis; we are now led to the even greater controversy of how to intervene.

As recently as February 1977, Gross, in a marvelously succinct review of upper airway obstruction in children, stated that "no statistically valid data exist proving the efficacy of nasotracheal intubation over tracheostomy."[8] Statistical significance aside, it is our purpose to crystallize the recent pediatric, anesthesia and E.N.T. literature, so that we may mount a rational approach at the bedside.

Tracheostomy

In 1974, a series of 55 cases of epiglottitis from Seattle was reported in the Archives of Otolaryngology.[10] The authors felt that the most serious error was to assume that the airway would remain patent, as 12 patients in an "observation" group underwent tracheostomy in less than ideal circumstances, while three experienced total respiratory arrest. The current protocol in Seattle at the University of Washington advocates routine tracheostomy once the diagnosis of epiglottitis is made, the reason — because of its "success in their hands."

A series of 83 patients was recently reported in JAMA from Tripler Army Hospital in Honolulu.[11] All

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their patients underwent tracheostomy; the only problems occurred in the "observation" group where three patients died and one suffered anoxic brain damage. Of course, this is really more of a protest against watchful waiting than against intubation. In contrast, at Madigan Army Medical Center nasotracheal intubation is the procedure of choice.[12] These disparate policies at two Army medical centers will hopefully be brought into line shortly by some kind of decree from Washington.

At Royal Alexandria Hospital for Children in Sydney, Australia, 61 cases of tracheotomy for epiglottitis were reported.[13] They perform the operation under general anesthesia with endotracheal intubation and suggest that "proper surgical technique" will result in no morbidity and low mortality. Again, the defense of tracheostomy was that it had proved "satisfactory."

Last year Fearon et al from Toronto reported a series of 72 patients with epiglottitis, of whom 69 underwent tracheostomy and three were intubated.[14] In defense of tracheotomy these authors cited evidence that deaths do occur in supraglottitis when an endotracheal tube cannot be passed through swollen tissues. They then glibly add, "There is no deliberate policy at the Hospital for Sick Children favoring tracheostomy rather than endotracheal intubation in the management of supraglottitis." However, the records show that 69 children were tracheotomized whereas only three were managed by nasotracheal intubation.[14] While 69 versus three may not indicate a "policy" in Toronto, it surely suggests a prevailing treatment modality. The authors further comment, "It is not our intention to deny that endotracheal intubation may be a perfectly safe and satisfactory method of ensuring airway protection in supraglottitis . . . Rather it is our contention that it is a safe procedure only in those hospitals which have an adequate number of anesthetists skilled in the intubation of small children, where there are otolaryngologists immediately available to carry out tracheotomy, and where there are good intensive care facilities."[14] Hopefully this is a description of the Toronto Hospital for Sick Children!

In summary, proponents of tracheostomy cite the advantages of low mortality and morbidity, easier nursing care and potentially easier replacement. Larger tubes and less dead space allow easier ventilation. If age is a factor, tracheostomy is probably better tolerated than endotracheal intubation in the adult. But we had the distinct feeling that the common denominator here was the physician's comfort with a time-tested procedure.

Endotracheal Intubation

There are several empirical objections to intubation for inflammatory airway obstruction: (1) the tube may increase edema in an already compromised airway, (2) it may slip out of the trachea, (3) the patient will be uncomfortable, (4) the tube lumen may plug with mucous, (5) respiratory difficulty may occur when the child is extubated and (6) subglottic stenosis remains a potential complication (as it is with tracheostomy).[15]

In spite of these objections, the last decade has witnessed an increasing number of reports dealing with endotracheal intubation as an alternative to tracheostomy in acute epiglottitis. Initially in the foreign literature, and more recently in the United States, these reports have gravitated to the pediatric and anesthesiology journals, while tracheostomy proponents congregate mainly in E.N.T. monthlies. Impressive data for the use of endotracheal intubation have surfaced from such divergent centers as Salt Lake City,[16, 17] Newark,[18] Denmark,[19] Sweden,[20] Denver,[21] Houston[22] and Columbus, Ohio.[23] These series over the past five years report a patient population of well over 500 cases in which there was essentially no mortality and very low morbidity. Mean time of intubation was approximately two days, and only a few cases of tracheal granulomata developed. Most authors felt that since intubation was usually required prior to tracheostomy the tube might as well be left in place. Other advantages reported were immediate securing of the airway, avoiding a surgical procedure in very sick children, shorter hospital stay, less problem with reintubation because of a dilatory effect on the airway, and fewer long-term complications. For example, Schuller and Birck noted a mortality secondary to intubation of 0 percent, and a 1.6 percent complication rate which is lower than the *mortality* rate (3.6 percent) in a large series of pediatric tracheostomies performed for croup and epiglottitis. Accidental extubation occurred 11 percent of the time but with *no* mortality, while accidental tracheostomy extubation occurred 1.3 percent of the time with an 8 percent mortality.[23]

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Most authors recommended a technique including general anesthesia, an otolaryngologist present to perform tracheostomy should it become necessary, a tube size smaller than a comparable tracheostomy tube for the particular age, and intubation by the nasotracheal route. Several fierce discussions were encountered concerning who should perform the intubation (e.g., in Houston the pediatric residents intubate in the emergency room, while in Salt Lake City the anesthesiologists intubate under general anesthesia in the operating room).

In contrast, there was almost universal agreement on the necessity for management in a hospital which could provide the trained personnel (nurses and physicians) in an intensive care facility. Sophisticated monitoring equipment and a pediatric respirator were thought essential. Also sine qua non was pulmonary toilet to include intense frequent suctioning, humidification of inspired air, changes of position, instillation of saline, and hyperinflation to help prevent bronchopneumonic complications.

Good agreement was also evident on the policy of tracheostomy if intubation was to be prolonged over several days.

Treatment of Epiglottitis and Croup

Tracheostomy	Short-Term Intubation
1. Potential complications of pneumothorax, mediastinal emphysema, etc.	1. Eliminates these risks
2. Risk of tracheal stenosis	2. Reduced risk of tracheal stenosis
3. Scars in neck	3. Eliminates scars
4. Hospitalization averages 6.5 days	4. Hospitalization averages 4 days
5. Problems with decannulation, especially small children	5. Eliminates problem with decannulation
6. Psychic trauma	6. Probably less psychic trauma
7. No special treatment center required	7. Requires specialized care in larger hospital
8. Mortality approximately 3 percent	8. No mortality
9. Accidental extubation: emergent	9. Accidental extubation: non-emergent
10. 10-15 percent infection rate	

Comment

The table summarizes the apparent advantages of short-term endotracheal intubation over tracheostomy for the treatment of epiglottitis and croup. Intubation eliminates the potential complications of pneumothorax, mediastinal emphysema, tracheal hemorrhage, etc. It reduces the risk of tracheal stenosis and eliminates surgical scars. Psychic trauma is probably lessened, and there is no problem with decannulation. While requiring specialized care in a larger hospital, duration of stay averages two days less. There is virtually no mortality and in the case of accidental extubation, replacement of the tube is not emergent.

E.N.T. acceptance of intubation has been less than warm, primarily because we have been doing tracheostomies for years, and fear the complications of intubation. The real crux of the matter comes in understanding and defining "short-term" and "long-term" intubation. It is reasonable to accept, in light of the previously cited studies, that nasotracheal intubation in croup and epiglottitis is by definition short-term (i.e., less than three days). We know from all our tracheostomized patients that this period is the usual time course encountered in these diseases (Fig. 1).

In 1965 infectious pediatric airway problems were handled by pediatricians and otolaryngologists. Ten years later it appears as though primary care has shifted to the anesthesiologists and pediatric pulmonologists. Common sense dictates, however, that optimal management should involve a triumvirate to include all three specialties in the care of these sick children.

To reiterate, in all cases of epiglottitis, but in less than five percent of laryngotracheobronchitis, airway intervention is the safest method of management. Today, nasotracheal intubation is the airway intervention of choice unless an intensive care facility and suitably trained physicians are unavailable. If intubation need be prolonged more than 72 hours, it would appear prudent to consider the standard tracheostomy and avoid the wellknown complications of long-term intubation. With this methodology, tracheostomies should all but disappear in the treatment of infectious airway obstruction. One interesting thought for 1984, though: if you really need a pediatric tracheostomy performed, you may have trouble finding a surgeon who has done one.

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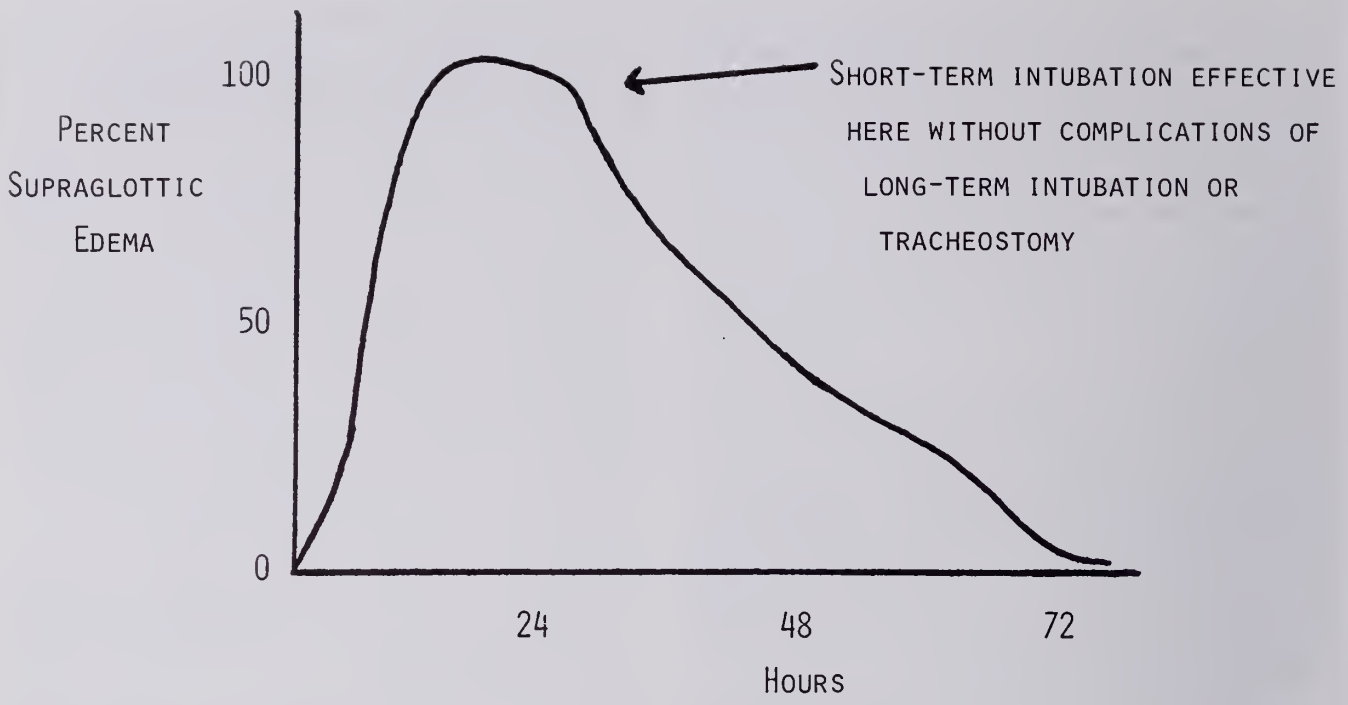


Fig. 1. — Nasotracheal Intubation in Epiglottitis.

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To be able to fill leisure intelligently is the best product of civilization.

Arnold Toynbee

Current Concepts of Cancer of the Head and Neck

J. Ryan Chandler, M.D.

Abstract: Cancers arising from the mucous membranes of the oral cavity, larynx, hypopharynx, and other organs in the head and neck region comprise approximately 5% of all cancers. Their symptoms appear early and all sites are readily accessible to inspection and examination. Early diagnosis and treatment increases likelihood of control and complete cure by such currently available measures as conservation surgery, combined ratiation therapy and surgery, chemotherapy as adjunctive measures, and radiation therapy for subclinical regional metastases. Newer technical aides, reconstructive surgical procedures, and increasing knowledge regarding the etiology and natural history of cancer of this highly visible and socio-economically important area should result in more "cures" with less disability.

"Cancer of the head and neck" refers primarily to those malignant neoplasms which arise from the mucous membranes of the oral cavity, larynx, and hypopharynx. However, the specified anatomic region of the head and neck has come to include by common usage the nose, paranasal sinuses, ear, salivary glands, thyroid gland, lymph nodes, skin and all structures above the clavicles. It excludes intraocular and intracranial neoplasms.

Although such cancers comprise but 5% of all cancers (excluding skin), their symptoms appear early. All sites are readily accessible to inspection and examination. Furthermore, all of these sites are highly visible and disturbances of function and/or appearance are readily noticeable by patients themselves, their families, and friends. Unfortunately, the total cure rate for all of these cancers has remained about the same during the past 30 years, in spite of quantum leaps in technology of modern anesthesia, blood replacement, and antibiotics. The reasons for this are difficult to analyze, but the primary reason seems to be the lack of awareness by the public and by physicians themselves. Most of these tumors result in early symptoms but unfortunately mimic the common infections and disorders of the upper aero-digestive tracts. Continued efforts to educate patients, physicians, and dental colleagues seem to be the only remedy for this problem.

Surgery is the oldest method of cancer therapy and still remains a frequently used and successful method of treatment; however, we now seem to have reached our limit in the amount of tissue which can reasonably be removed. We have devised ingenious methods of reconstructive surgery to repair extensive anatomical and functional defects resulting from far advanced cancers, only to find that many of our patients are dying of disseminated disease. Clearly, the need now is to determine ways of preventing cancers as well as to destroy systemic metastases once the primary tumor has been controlled.

Current concepts in diagnosis, treatment, and subsequent management of patients with cancer of the head and neck will be reviewed.

Conservation Surgery

Conservation surgery is a term used to describe those surgical procedures performed for the removal of all cancerous tissue while still preserving function.[1] While a total laryngectomy would be highly successful for the cure of an early carcinoma arising on one vocal cord, it is analogous to "overkill." The principle of conservation surgery is that the complete cancer and a small amount of surrounding normal tissue can be removed from its host while preserving sufficient normal structures that function can be maintained. This includes not only phonation, but respiration, deglutition, lower respiratory

The Author

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Dr. Chandler is Professor and Chairman of the Department of Otolaryngology at the University of Miami School of Medicine. He is a graduate of Duke University and is a member of the American Society of Ophthalmology and Otolaryngology, a Fellow of the American College of Surgeons and member of the American Laryngological, Rhinological and Otological Society, Inc. He is also a member of the American Otological Society, the American Laryngological Association, the American Society for Head and Neck Surgery and the Society of Head and Neck Surgeons.

tract protection and, of course, the patient's cosmetic appearance.

Not too long ago, total laryngectomy was the operative procedure of choice for those carcinomas arising in and even localized to the epiglottis, base of the tongue, aryepiglottic fold, ventricular bands, and other supraglottic structures. The concept of conservation surgery has demonstrated that all of the structures above the true vocal cords can be removed in a true en bloc cancer operation with no decrease in the cure rate, thus preserving the function of the larynx. Carcinomas arising on one vocal cord or those involving the anterior portion of the opposite vocal cord, its arytenoid cartilage, and supporting structures, can be treated with radiation or removed with appropriate conservation of function. The ultimate cure rate in such patients has proved to be equal to that achieved by total laryngectomy.

Another area in which conservation principles are applicable is cancer of the floor of the mouth, tongue, and palate in which a portion or as much as one-half of the mandible may require removal. It was formerly thought that lymphatics passed through the periosteum and that their control required sacrifice of the entire segment of adjacent mandible. This leads not only to cosmetic deformity, but to considerable disturbance of function as a result of the postoperative mandibular shift. The utilization of partial marginal resection of only that bone adjacent to the tumor has resulted in preservation of function following such cancer surgery and has not decreased the total cure rate.

Our current thoughts regarding the management of such patients is that whenever the lesion lends itself to conservation surgery, such surgery is the treatment of choice.

Combined Radiation Therapy and Surgery

While there is general accord that the combination of radiation therapy and surgical excision for most large cancers of the head and neck leads to an increased cure rate, there is currently no unanimity of opinion regarding the sequence in which such combination therapy should be administered. We seem to have reached the zenith of employing radiation therapy prior to surgery with the objective of eradicating peripheral cells and facilitating the surgical procedure. The increased morbidity and mortality associated with the surgical procedure following such radiation therapy has resulted in a reappraisal of the costs of the advantages gained. It has now been well demonstrated that radiation therapy can sterilize subclinical disease, and that when administered in tolerable doses following a properly devised surgical procedure, can be equally effective in improving the total cure rate.[2] Accordingly, it has become our general policy here at the University of Miami Medical Center that in most instances, wide surgical excision of the lesion is considered the treatment of choice, to be followed by appropriate radiation therapy. The surgical pathology report is an important aid in planning subsequent treatment. This does not apply to those small well localized lesions without regional metastases and in which the cure rate is 60% or higher.

The surgical procedure required for the eradication of a large cancer can be more appropriately planned prior to subsequent changes in the tumor's extent and appearance. Added to this is a significant decrease in morbidity and mortality. It appears that we may be entering an era in which surgical removal of all cancer or most of the gross cancer is the procedure of choice and that residual subclinical disease can be destroyed by appropriately designed and administered radiation therapy and/or cytotoxic drugs.

Chemotherapy

There have been remarkable instances of total regression of large cancers of the palate and pharynx in response to chemotherapy. This attests to the emerging importance of chemotherapy not only as palliative therapy for patients with far advanced, inoperable tumors, but as adjuvant therapy for planned therapeutic attacks on curable lesions. Methotrexate remains our standby. Bleomycin is useful in short courses. Cis-platinum seems to hold the promise as being one of the most potent cytotoxic agents yet devised, insofar as squamous cell carcinoma is concerned.

Methotrexate given orally is just as effective as when given intravenously or intra-arterially, and in weekly amounts of up to 25 mg M^2, results in no more toxic effects than smaller amounts given continuously or intravenously. Some tumors are very responsive. It is the variability and unpredictability of response which is the most puzzling thing to us now. Various centers and cancer study groups have joined in a cooperative effort to place high risk patients with stage III and IV disease into research protocols using chemotherapy, surgery and radiation hoping to achieve higher cure rates.

Radiation Therapy for Neck Nodes?

During the past 15 years, evidence has accumulated that advances in radiation therapy, consisting of a better knowledge of radiation physics and supervoltage agents such as cobalt, the electron beam, and the linear accelerator have the ability not only of "sparing the skin" but of resulting in a more homogeneous application of

the cancer destroying ionizing radiation. Modern radiation therapy is effective in sterilizing not only subclinical disease in the regional lymph nodes, but can frequently destroy lymph node metastases as large as 2 cm^2.

We have demonstrated that radiation therapy can be as effective as a radical neck dissection in controlling small neck metastasis.[3]

Review of an unselected series of 360 radical neck dissections demonstrated the following:

1) 23% of our patients have received a therapeutic dose of radiation therapy to full neck fields prior to surgery.

2) When original neck staging was N_0 or N_1 and there were no palpable nodes prior to the salvage surgical procedure following high dose full neck irradiation, the neck dissection specimen contained positive nodes in only 18% (4/22) of cases.

3) When original neck staging was N_2 or N_3, but there were no palpable nodes prior to the salvage surgery, occult disease was found in 50% (5/10) of neck dissection specimens.

These findings support our current position that an elective neck dissection need not be included in a salvage surgical procedure following radiation failure of the primary tumor when N_0 or N_1 necks have received high dose radiation therapy to full neck fields. On the other hand, when original neck staging was N_2 or N_3, the high incidence of occult disease justifies the increased morbidity and mortality of concomitant neck dissection.

Reconstructive Surgery

With the discovery of the delto-pectoral flap approximately 15 years ago, the art of immediate and delayed reconstructive surgery was given a great boost. This flap is now the workhorse of head and neck surgeons for the construction of the cervical esophagus and pharynx, protecting the carotid artery, providing coverage for jaw reconstruction, and to pemit excision of large areas of skin in the head and neck. The forehead flap, while highly dependable, is cosmetically unacceptable to women and men, and we are currently depending more and more on the delto-pectoral flap. Its use and that of other regional flaps and tissue have resulted in a decrease in the number of operations required for reconstructing large defects in this area. It has resulted in an increased quality in life for all of these patients requiring such surgery.

Cryosurgery

Cryosurgery has been utilized by many head and neck surgeons for palliation as well as for cure of some patients with cancer of the head and neck. We have been particularly interested in its use for recurrent or persistent cancer of the head and neck following conventional therapy. As such, it has become a major surgical procedure and is associated with a considerable degree of morbidity and mortality.[5]

We have nonetheless treated 106 patients in the past 11 years, with the objective of complete cure in 101. We have found that the cryosurgical approach to cancers of the floor of the mouth for midline lesions and for the palate and tonsillar regions avoids the problems of composite resections with their considerable morbidity and mortality. Furthermore, cryosurgery to the nasopharynx, a site for which no other surgical procedure is applicable, has resulted in four of 11 patients being free of disease more than two years following surgery.

For 90 patients with recurrent tumors, our current local control rate of two years or more is 19%.

Cryosurgical salvage should be considered in any patient with persistent disease following radiation therapy and/or surgery.

Immunotherapy

The place for immunotherapy in the treatment of patients with cancer of the head and neck must await advances to be made in the future.

Laetrile

I think it is a useless nostrum and an appalling commentary on the power of vested ill-informed interests combined with the understandable fear and anxiety of our patients, their relatives and well-meaning friends. However, it is now legal to manufacture and dispense it in Florida. Let's try to keep an open mind and continue to follow our patients in order to better document results or lack of results due to its use. We have not heard the last of this.

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● Dr. Chandler, 1700 N.W. Tenth Avenue, Miami 33610.

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

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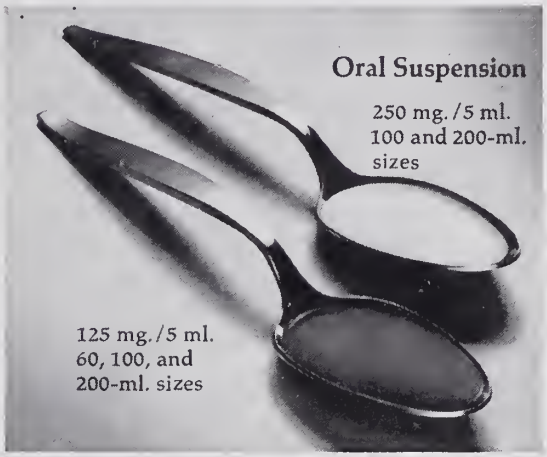
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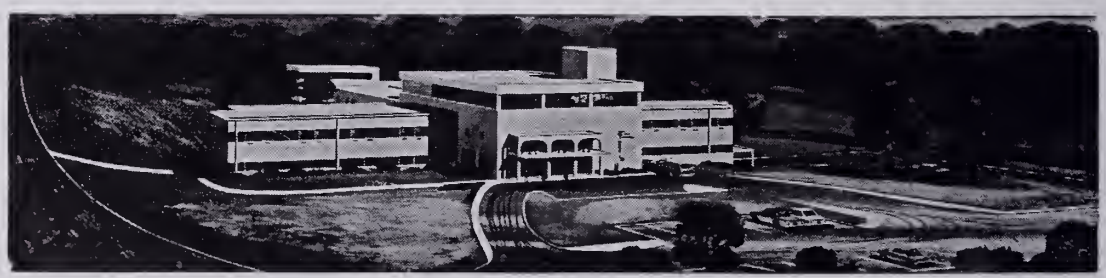
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Talk is cheap.

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As a businessperson, you know it's more effective to anticipate a problem than to react to one. What you may not know is that child abuse, child neglect and poor parenting patterns lead to juvenile and adult crime, legal system overloads, lost productivity and increased taxation. Local services to prevent child abuse are understaffed and overworked. Some of the actions you can take to eliminate these problems are listed below. Commit yourself and your company to one or more. Help stop the hurt.

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- ☐ We want our employees to know more about the problem. Please send us _____ copies of the pamphlet "Prevent Child Abuse" at 10¢ a copy for 100 copies or more.
- ☐ We will provide active support to local organizations which can help prevent child abuse. For openers, we will find out the names of these organizations.
- ☐ We will plan a day for employees' children to visit our place of work to learn what we do and why.
- ☐ We will volunteer our employees' time and talent to community child abuse prevention programs.
- ☐ I don't spend enough time with my children. Tonight I am going home early to find out who my children are.
- ☐ We want to start helping right now. Enclosed is a check for $_____ . Please give our company _____ memberships in the National Committee for Prevention of Child Abuse, at $10 each. Attached is a list of names and addresses.

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ORGANIZATION

Dr. Dockery Named Associate Dean At University of Florida

J. Lee Dockery, M.D., former Vice President of the Florida Medical Association and currently a member of the Board of Governors, has been appointed Associate Dean for Academic Affairs at the University of Florida College of Medicine.



Dr. Dockery

The appointment was announced by William B. Deal, M.D., who only last spring was named Dean of the College.

"Dr. Dockery brings a unique combination of talents — including past experience in private practice, recognition by students as an outstanding 'Teacher of the Year,' and contributions to scientific literature," Dr. Deal said. "I am sure his talents will be utilized fully in this position."

Dr. Dockery is Associate Professor of Obstetrics and Gynecology at the University of Florida, which he joined in 1975 after several years of private practice in Miami with O. William Davenport, M.D., currently President of FMA.

During 1977-78, Dr. Dockery was Vice President of FMA. He then accepted a four-year appointment as a member of the Board of Governors representing Medical District "A."

Dr. Dockery is a former Chairman of the FMA Council on Scientific Activities. He was Program Chairman for the American Medical Association's Mid-Winter Scientific Program in Miami Beach in December, 1977.

DCMA Installs Its Second Walter C. Jones, M.D.

In 1922, Walter C. Jones Jr., M.D., was enrolled as the 23rd member of the Dade County Medical Association. Six years later he was installed as President of what is now Florida's largest county medical society.

This summer, 50 years later, Dr. Jones' son, Walter C. Jones III, M.D., took up the presidency of DCMA.

The significance of this son-follows-father event was appropriately observed on July 11 at the Annual Meeting of DCMA. The younger Dr. Jones presented his father with a special commemorative gavel.

The elder Dr. Jones is a Fellow of the American College of Surgeons and for many years was Director of the Department of Surgery at Jackson Memorial Hospital.

The new DCMA President received his M.D. degree from the University of Miami School of Medicine. He completed internship and residency training at Jackson and at the present time is Chief of Staff at Doctors Hospital in Coral Gables.



Walter C. Jones III, M.D., new President of the Dade County Medical Association, is congratulated by his father, Walter C. Jones Jr., M.D.

Scientific Speaker Registry Operational At Foundation Headquarters

The Florida Medical Foundation can assist county medical societies and community hospitals in arranging scientific programs through a service established recently.

The Scientific Speaker Registry contains the names of more than 320 Florida physicians who are available to speak on various topics within their specialties, according to Robert H. Threlkel, M.D., of Jacksonville, Chairman of the FMF Committee on Medical Education.

County medical societies, hospitals, specialty groups and others were asked to supply names of member physicians who are available to present scientific programs, and the response has been extremely good, Dr. Threlkel said.

The program is not to be confused with the FMA Speakers Bureau which secures speakers for lay audiences.

The registry is maintained at the FMF/Florida Medical Association Headquarters in Jacksonville. A card is maintained on each participating physician. It contains such information as his address, telephone number, specialty, and either the general or specific nature of the subjects on which he is prepared to speak. In some cases information is maintained on individual travel limits, expense arrangements, etc.

Many speakers are cross-indexed to one or more additional specialties, using specialty codes recognized by the American Medical Association. For example, an orthopedic surgeon with special interest in children's problems is listed under both orthopedic surgery and pediatrics.

Dr. Threlkel said the registry cannot provide the names and information on all participants in the program in response to any one request. Program directors, when requesting assistance, should specify the types of speakers they want by specialty, geographical area, etc.

The service is available free of charge to FMA-recognized specialty groups, county medical societies, voluntary health associations, hospitals and other sponsors of continuing medical education activities.

Assistance can be obtained by calling or writing to: Mr. Edward D. Hagan, Director of Scientific Activities, Florida Medical Foundation, P.O. Box 2411, Jacksonville, Fla. 32203, telephone (904) 356-1571.

Dr. Threlkel said his Committee will welcome additional physician participation in the registry. Information can be obtained by communicating with the Foundation.

FMA Speakers Bureau Offers Dr. Annis To State Organizations

The Florida Medical Association Speakers Bureau is accepting engagements for Dr. Edward R. Annis to address organizations in the State.

One of organized medicine's most dynamic speakers, Dr. Annis is a Past President and Past Trustee of the American Medical Association. He is available to express medicine's point of view on current topics to state, regional or national groups meeting in Florida.

Dr. Annis is not available to address county medical societies or medical specialty groups, the Bureau said.

Physicians with knowledge of organizations that might be interested in engaging Dr. Annis should contact: Speakers Bureau, Florida Medical Association, Inc., P.O. Box 2411, Jacksonville, Fla. 32203, Telephone (904) 356-1571.

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LOSS PREVENTION BULLETIN NO. 4

GENERAL

THE TIMELY REPORTING OF INCIDENTS THAT MAY BECOME CLAIMS cannot be overstressed. It is a late symptom in the claims-handling process when our first knowledge of a claim is when the physician receives mediation papers. Upon receipt of mediation papers, we have only 21 days (usually less by the time we are notified) in which to accomplish an investigation, reach a decision of whether or not to mediate, and file the proper mediation papers. Had we been notified of the event soon after it occurred, we would have had time to perform a complete investigation, to prepare an effective defense for mediation, and possibly to solve the problem before litigation. Many cases, when reported early, have been settled directly with the patient without involvement of a plaintiff attorney and the attending extra expense.

There are two areas of practice habits that, if improved, could reduce our losses considerably:

1. CARELESS TALK GENERATES CLAIMS. While there is no way to effectively measure the impact of "loose talk" in the production of claims, we do think that this is a factor in most of the claims we are defending. A few careless words spoken by a physician to a patient concerning the patient's previous medical care can precipitate a claim. Be careful how you and your staff comment on previous medical care. Be fair, and honest, when passing judgment on the quality of previous treating physicians.

2. COMMUNICATION BETWEEN THE EMERGENCY AND RADIOLOGY DEPARTMENTS NEEDS CONSTANT MONITORING. Several claims have arisen from improper x-ray study requisitions, incorrect views, and missed fractures. The lack of proper patient follow-up by the Emergency Department when a mistake has been discovered has generated several claims. Emergency Physicians and Radiologists should review and, if necessary, correct the procedures used in their institutions for proper patient follow-up.

Since our last *Loss Prevention Bulletin*, the following cases have been settled:

ANESTHESIOLOGY

A claim has been settled for damage to a fixed bridge sustained by an oral airway used during surgery. This is often unavoidable but should be discussed with the patient at the time informed consent is obtained.

DERMATOLOGY

A patient with a history of keloid formation had a xanthoma removed from a lower eyelid. The physician used Trichloracetic acid, and a large unsightly keloid resulted. Perhaps no treatment would have been preferable.

OBSTETRICS-GYNECOLOGY

The patient had two abortion attempts by one physician and a third attempt and a hysterotomy by a second physician to terminate her pregnancy. The insured failed to take note of the last menstrual period, did not obtain a history, and failed to examine the patient. Such a case is indefensible.

ORTHOPEDICS

Both the orthopedist and the radiologist failed to detect a fracture of the wrist that was discovered by a subsequent treating physician. Expert testimony was available to prove that the patient's condition deteriorated during the interval. The case was settled.

NEUROLOGY

The physician performed a bilateral facet rhizolyses, and the patient sustained a burn on her buttocks from an improper grounding needle.

RADIOLOGY

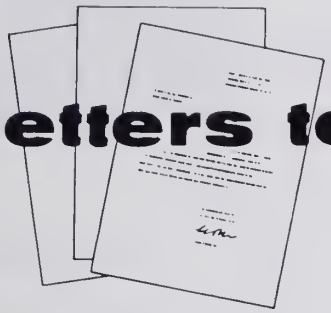
See Orthopedics.

SURGERY, GENERAL

A hysterectomy was performed on the sixth day following a D&C and conization, and the patient developed a fatal postsurgical infection. The medical consultants questioned the timing of the hysterectomy and the management of the infection.

SURGERY, PLASTIC

An ectropion resulted from a bilateral blepharoplasty that required further surgery to correct.



Letters to the Editors

IN APPRECIATION

Board of Governors
Florida Medical Association
Jacksonville

Gentlemen: The invitation to participate in the caucuses of the Florida Delegation at the AMA annual meeting in St. Louis, June 18-22, 1978, is most appreciated. Your financial assistance enabled me to attend the AMA annual convention and supported my participation in the meetings of the Florida Delegation. It is with regret that I note the defeat of Dr. Jere Annis. This defeat will obviously not blemish the record of this outstanding physician who has demonstrated through the years his unyielding support for fellow physicians both in practice and academic medicine.

My experience with the Florida Medical Association over the past year has certainly aided my professional development. As a young physician, I have witnessed the commitment of our state medical association to encourage the participation of other young physicians in the affairs of organized medicine. Your vision of the future will be sustained by the development of articulate and effective physicians who will provide the future leadership that is so desperately required to insure the well-being of a new generation of patients and physicians.

As I enter the practice of Pediatrics in Brevard County, I look forward to many satisfying years of participation in the activities of the Florida Medical Association. Thank you again for your invitation and generous assistance.

Richard K. O'Hern, M.D., Ph.D.
Rockledge

(Editor's Note: At the time he attended the AMA Convention, Dr. O'Hern was Chief Resident and Assistant Professor of Pediatrics at the University of Florida College of Medicine.)

FORMER STUDENT WRITES

Gerold L. Schiebler, M.D., Editor
Edward D. Hagan, Executive Editor
Journal of the Florida Medical Association
Jacksonville

Dear Dr. Schiebler and Mr. Hagan: I have received a copy of *The Journal* today and was reminded of my pleasant associations with it. My apologies to both of you for not responding sooner to Mr. Hagan's earlier letter. Your kindness is appreciated as only it could be by a Floridian now inhabiting the desolate desert area.

Terry and I are now settled into our new home. I would be pleased to continue receiving *The Journal.* I plan on returning to the trees and water of Florida as soon as possible; the articles will keep me in touch with the situation there.

Thank you again for your consideration. I know that I have benefitted academically and socially from the opportunities that you have given me.

Alan D. Zablocki, M.D.
El Paso, Texas

(Editor's Note: Dr. Zablocki, a 1978 graduate of the University of South Florida College of Medicine, and *The Journal*'s first student Assistant Editor, is now enrolled in a surgical residency program in El Paso.)

Great ideas need landing gear as well as wings.

Adolph A. Berle, Jr.

CUARTO SEMINARIO MEDICO PAN AMERICANO
OCTUBRE 16-20, 1978
TOTALMENTE EN ESPAÑOL

Mount Sinai
MEDICAL CENTER OF GREATER MIAMI

Director del Seminario:
FEDERICO R. JUSTINIANI, M.D.
Profesores:
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MANUEL SIVINA, M.D.
MANUEL VIAMONTE, JR., M.D.
MARIA VIAMONTE, M.D.
NOEL ZUSMER, M.D.

Para más información e inscripción diríjase a: Continuing Medical Education, 4300 Alton Road, Miami Beach, Florida 33140.

CONFERENCIAS SOBRE: 9:00 AM - 1 PM
(Lunes a Viernes)
ENFERMEDADES COLAGENAS, ANEURISMAS DE LA AORTA, LINFOMAS, HIPERTENSION ARTERIAL, ENFERMEDADES PULMONARES OBSTRUCTIVAS CRONICAS

SESIONES de TRABAJO: 3:00 PM - 5:00 PM
(Lunes a Jueves)
SONOGRAFIA ABDOMINAL, ISOTOPOS EN CARDIOLOGIA, RESUCITACION CARDIOPULMONARY, TOMOGRAFIA COMPUTADA ABDOMINAL

CUOTA de INSCRIPCION: $150 (incluye recepción y banquete de despedida)

Este seminario está aprobado para 26 horas "Prescribed" por la AAFP; para 26 horas Mandatorias por la FMA y para 26 horas en la Categoría I por la AMA.

CUARTO SEMINARIO MEDICO PAN AMERICANO
OCTUBRE 16-20, 1978
en el Wolfson Auditorium



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Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Annual Review of Medicine: Selected Topics in the Clinical Sciences. 641 Pages. Price $17.00. Annual Reviews, Inc., Palo Alto, California, 1978.

This volume is the 29th in this series which reviews, as the title states, Selected Topics in Clinical Sciences. A broad range of subjects is covered, but the volume in general is divided into sections in which there are a series of articles based either upon body systems or selected medical topics. As have been true of past editions each of the articles is well standardized in its overall format beginning generally with an introduction, an elaboration of the essential information, and conclusion. Virtually all of the articles in each of the sections are authored by national or international authorities in their field. They are lucidly written and have sufficient graphic data to be clear and understandable, and each is amply supported by additional bibliographic citation.

In the terms of general interest, the articles present information which is generally quite detailed, condensed, and highly scientific. They are clearly intended for the physician who wishes to have, in a summary form, a succinct statement of some of the newer advances of selective areas of medicine. The text would certainly be most appropriate for such individuals but not particularly practical for those who are looking for details usually set forth in standard textbooks of medicine. The table of contents clearly reveals that the subjects which are covered are of primary interest to practicing internists and family practitioners with relatively little interest or value to physicians practicing in the operative specialties of medicine. The volume should, however, be included in every university, medical library and in every hospital.

Roy H. Behnke, M.D.
Tampa

Dr. Behnke is Professor and Chairman, Department of Internal Medicine, University of South Florida, Tampa.

Patients by Polly Toynbee. 279 Pages. Price $8.95. Harcourt, Brace and Jovanovich, New York, London, 1977.

The title of this interesting nonfiction work is misleading. It would have been more appropriate if the title had remained "Hospital" as it was published in Britain. In fact, it is the author's account of some five months spent as an observer, in and around "The London Hospital." She recounts her experience in an anecdotal manner in a series of sketches which do not, for the most part, have a central character. The author very seldom interjects any indepth evaluations of either the institution, individuals, or the National Health Service. There are some impressions of the characters which certainly impart a feeling of empathy or of antipathy. The character sketches are well done and easily identifiable especially to those of us who have spent some time in a large hospital. As a matter of fact, it was difficult for me not to visualize wards and clinics at Charity Hospital while reading of similar areas in "The London."

The overall tenor of the book seems to suggest that the care received in this large metropolitan hospital is excellent. There is a warmth in the author's approach to certain patients and an understanding, unusual in a lay person, in her impressions of the professionals and some of the more difficult patients. It would be easy to draw conclusions based on this book as to the quality of British medicine; however, I do not feel that the author intended to impart any such evaluation. The book is best read as an account of a lay person's experience in a large hospital. To read more into it would not be doing the author justice.

The style of writing is simple and interesting. This short book is well worth an evening or two of your valuable time and I would recommend it highly for such entertainment.

It is not a social statement, nor is it an education in the workings of a system of health delivery, and I do not feel that it was intended to be either. It is simply light, interesting, entertaining and well done without any pretense of being a highly consequential piece of literature.

Charles J. Kahn, M.D.
Pensacola

Dr. Kahn is an internist who practices in Pensacola. He is a former Speaker of the FMA House of Delegates. Presently he is a member of the FMA Board of Governors.

Surviving by Jean Pond. 136 pages. Price $7.95 (hard cover). Hill and Wang, Division of Farrar, Strauss and Giroux, New York, N.Y., 1978.

Jean Pond, accomplished writer and wife of NBC correspondent Geoffrey Pond, writes about her intimate acquaintance with her own brain tumor. She describes in sharp detail her struggle with the symptoms of her tumor — daily headaches and beginning clumsiness. She is finally referred to the neurologist who takes her complaints seriously and strongly suspects a brain tumor. However, after diagnostic testing the neurologist is unable to obtain a surgeon who will operate on the patient because New York is involved in the "doctors strike" related to the malpractice insurance situation at that time. After several grand mal seizures, she is declared "an emergency" and surgery is performed. She describes in sensitive terms her own perceptions of her recovery in the intensive care unit and progressing on to convalescence. A steroid-induced psychosis occurring shortly after surgery is vividly recreated for the reader in a stream-of-consciousness style which few authors can accomplish well.

Recommended for physicians and health care personnel. Not recommended for the average patient anticipating brain surgery.

I am glad I read it.

F.N.V.

Death Sails the Bay by John R. Feegel, M.D., J.D. 296 pages. Price $1.95 (paperback). Avon Publishers, New York, N.Y., 1978.

John Feegel, Tampa forensic pathologist, has written his second thriller. The first, entitled *Autopsy*, appeared about two years ago. The story centers around the efforts of a young pathologist to escape his humdrum daily existence and somewhat drab marriage. The setting is the Tampa Bay area where the author lives.

A pleasant diversion for an evening or so.

F.N.V.

Reading is to the mind what exercise is to the body.

Sir Richard Steele

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Annual Review of Neuroscience with 28 contributing authors. 506 Pages. Illustrated. Price $17.00. Annual Reviews, Inc., Palo Alto, California, 1978.

Heart Attack! A Question & Answer Book by Oscar Roth, M.D. with Lawrence Galton. 262 Pages. Price $8.95. Lippincott, New York, 1978.

Pharmacological and Toxicological Perspectives of Commonly Abused Drugs by Darryl Inaba, Ph.D., E. Leong Way, Ph.D., Kenneth Blum, Ph.D. and Sidney H. Schnoll, M.D. 44 Pages. National Drug Abuse Center, Rosslyn, Virginia, 1978.

Review of Medical Microbiology, 13th Edition by Ernest Jawetz, M.D., Joseph L. Melnick, Ph. D. and Edward A. Adelberg, Ph.D. 550 Pages. Illustrated. Price $12.00. Lange Medical Publications, Los Altos, California, 1978.

Currents in Alcoholism, Biological, Biochemical, and Clinical Studies, Edited by Frank A. Seixas, M.D. 601 Pages. Illustrated. Price $31.50. Grune & Stratton, Inc., New York, 1978.

Controlling the Use of Therapeutic Drugs: An International Comparison edited by William M. Wardell. 263 Pages. American Enterprise Institute for Public Policy Research, 1978.

Visionetics, The Holistic Way to Better Eyesight by Lisette Scholl with John Selby. 222 Pages. Illustrated. Price $4.95. Doubleday & Company, Inc., New York, 1978.

Directory of Pathology, Training Programs, 1979-80 by the Intersociety Committee on Pathology Information, Inc. 470 Pages. Illustrated. Price $25.00. Geo. W. King, Co., Baltimore, 1978.

Measuring Medical Education, The Tests and the Experience of the National Board of Medical Examiners, Second Edition, by John P. Hubbard, M.D. 187 Pages. Illustrated. Price $12.00. Lea & Febiger, Philadelphia, 1978.

Basic and Clinical Immunology, 2nd Edition by H. Hugh Fudenberg, M.D., Daniel P. Ftites, M.D., Joseph L. Caldwell, M.D. and J. Vivian Wells, M.D. 758 Pages. Illustrated. Price $14.50. Lange Medical Publications, Los Altos, California, 1978.

Sniff, Sniff, Al-er-gee by Claude A. Frazier, M.D. and Illustrated by Paul H. Carlson. 36 Pages. Prices $5.65 (hardcover) $2.65 (paperback). Johnny Reads, Inc., St. Petersburg, 1978.



Others Are Saying

Stress

Joseph C. Von Thron, M.D.

What is stress? Everybody has it. Everybody talks about it. Few people really take the trouble to find out what it is.

Well, it's American. Stress is succeeding. Stress is loving. It is being accepted. It is being admired. It is being approved. And there is no way you can avoid it. We don't want you not to have these stresses because these things are fun. We all want them.

I am reminded of the song that Dean Martin made famous, "You're Nobody Till Somebody Loves You." If you don't have somebody loving you, then you're suffering a different kind of stress; that is harmful stress. Let's put it in the proper context. We call that distress.

Medical science today is showing that mental tensions, frustration, insecurity, aimless existence in life, are causing more heart disease, more high blood pressure than what is happening to the Dolphins or those men who are working so hard on the football field. Yet I have heard many people say from time to time, "Gee, I wish I could be like John Jones — nothing ever bothers him." Well, there are two things wrong with that statement. One, on the exterior he doesn't show what is bothering him and he has a very stressful life. He is burning up inside with his cardiovascular system slowly being destroyed, or maybe developing an ulcer, or his blood pressure is rising. Or two, on the other hand, John Jones might have during his adolescence lived on the wrong side of the street and never became involved. He is not living. Stress is the spice of life. It is no fun to go through life with no runs, no hits and no errors. So, I worry about people in my community who are retired. There are a great number of them. I remember the quote of Ben Franklin: "There is nothing wrong with retirement as long as it doesn't interfere with your work."

If you think just for a moment about the great accomplishments of man in this world of those who have lived a long time, succeeded, and worked hard right up to their deaths, you think of Winston Churchill, Doctor Schweitzer, George Bernard Shaw, Henry Ford, Queen Victoria, Charles DeGaulle, because they all had an aim in life. It is natural. It is human to dream. But you have to be able to dream. If you can't dream, you become unhappy. You become a spectator. You live a vista experience, sitting there and watching the television set all the time. So you must be involved, or you end up being like a John Jones who didn't have the ability to dream; you couldn't get excited. But in doing this, everyone has his own limits. What might be the maximum for you in emotional stress or physical stress, might be minimum for another person. Because of this you must consult your physician — just make sure that you are not exceeding what your body or your mind can stand.

I can't help but remember the night that Johnny Carson came out on T.V. without his shirt. He was wired to an electrocardiography machine, and they showed what happened to Johnny Carson. Now, he wasn't running the mile. He wasn't involved in a basketball game. He was merely putting on his Tonight Show that he has been doing for 16 or 17 years. Then they played back what happened to Johnny Carson. I will only talk about the pulse. The emotional stress that this man was going through. Prior to coming on the show for the first five minutes before they said, "You're on the air," his pulse, which when normal would probably run between 70 and 90, went to 140. For the first minute during his monologue it was 160. Then as he slowly felt more comfortable, enjoying what he was doing again, it slid back to 80 or 90 after three minutes into the show. But this was enjoying stress. This was normal stress to Johnny Carson. He could take it.

We look at our school system. What do they do for stress? We have physical education. Part of the reason we have physical education is to try to teach you how to play basketball, football and soccer. But the other reason is to have a balance of emotional and physical activity. So, the businessman should have a balance of physical and emotional activity too. The man who sits behind the desk should have some physical outlet when he goes home or on the weekend so that he is balanced, as is the student in the school.

I am sure you all have seen the show, Animal Kingdom. It is instinctive in an animal, in the concept of all animals, to plan ahead. They do three things: animals want to accumulate food, want to live in a highly organized community and want their own living quarters that belong to them. It is a characteristic of the ants, the bees, the squirrels and the beavers. It is like putting money in the bank for the future.

So we as humans have the same impulses and the same drives because we, too, are animals. Our entire society has the same drives. We want to accumulate food, put it aside for the future. This is like putting money in the bank. We want to live in a highly organized community with telephones and roads and our cities. We want living quarters. That is our fortress, no fence around it, but our home. We want to accumulate security and comfort just like the rest of the animals.

Any occupation you have to do for a living is frequently called work. To some part-time, it is fun. But if you don't have to do it for a living, it is fun. I am talking about gardening, cutting the lawn, playing golf, or even fishing. Now I love to cut my own lawn. But if I had to cut seven lawns every week, I am sure that my desire to cut lawns would diminish rapidly. One of the reasons Jack Nicklaus is such a great golfer, and he has many reasons, is his love of fishing — fishing is his escape mechanism. Now I am not saying he doesn't enjoy playing golf on the tour, but at times it must be quite demanding and the emotional stress, difficult. So what does he do? He grabs a fishing pole and finds his way out. Each and every one of us, if work is not demanding physically, could have exercise programs outside of those to relieve this stress; again under your doctor's direction.

What can you do at work? How can you avoid stress at work? Well, I think there are three ways you can do it. First, you should eliminate the most distasteful and distressful parts of your job early in the day so you have only one hour of stressful thinking instead of eight hours; instead of leaving it to the last like most people do. Second, you should delegate to other people, if possible, the part that is stressful to you. Third, you should avoid confrontations with those people who upset you.

I had a gentleman in my practice who liked to bet on pro-football games. He really spent every weekend making sure he had $5.00 on every game that was on T.V. He was going through more stress than the players on the field as he lined up his games. Finally, I had to explain to him it would be much better if he were outside working in the garden, cutting the lawn or doing something else other than watching those games. I finally convinced him. Now he cuts the lawn and pays less attention to the football games. I am sure he is going to live a longer time.

Reprinted from HRS ACCESS, June-July, 1978.

Dr. Von Thron is a past president of the Florida Medical Association, the Florida Academy of Family Practice and the Brevard County Medical Society and a member of the medical advisory committee of Cape Canaveral Hospital. This paper was presented before the "Is Your Lifestyle Self-Destructing?" Seminar sponsored by the Florida Council of 100 and Blue Cross-Blue Shield of Florida, September 29, 1977, in Miami.

Lifestyle — A Collision Course

Vernon B. Astler, M.D.

Spectacular increases in health care costs and expenditures in recent years have not been accompanied by improvement in the health of Americans.

Americans seem to have nurtured an ingrained but comfortable illusion that better health is simply for sale, or, more simply stated, the more we spend, the healthier we are going to be. And I thing some of the available facts would oppose this view.

What is perhaps more important is that this illusion may be deflecting people from appropriate behavior and actions that could prove more important to their health and to their longevity.

In 1950 we spent $12 billion for health and medical care in the United States. By 1975 this figure had risen to $116 billion, almost a ten-fold increase. I hear from more updated statistics that it has risen to $139 billion annually. That does not surprise me because the 1975

figure was a ten-fold increase from 1950.

In a similar period of time, our per capita expenditure for health services has risen from $78 per person to $530 per person each year. The federal government alone spent well over $41 billion for health care in 1974, compared to only $3 billion in 1950.

We observe that during the ten-year period between 1965 and 1974, the government increased its health payments by 333 percent.

One can easily see that government has engaged in massive expenditures for health care, and we have invested greater portions of our total wealth into this area. In a similar way, the government has become increasingly involved in the distribution and supply of medical manpower in all categories. Massive federal support has been furnished to increase enrollments and development of new medical schools. In 1974 we had some 25 percent more medical schools than we had in 1951, and we graduated 84 percent more medical doctors. However, the simple increase in numbers of physicians may not increase the health of America.

Please remember that health is our goal. In fact, there is some evidence that increased numbers of physicians may only increase the cost of medical care and not necessarily increase the health of Americans.

Recently in Ontario, Canada, a study there showed that every new doctor who entered the province cost the government around $150,000 annually. Therefore, they have limited the entrance of physicians into their province with the hope of lowering or containing medical costs.

Spectacular increases in health expenditures have not been accompanied by improvement in the health of Americans. After a 50-year period of marked improvement, the crude death rate for the United States ceased to improve during the 60's and 70's. It has now remained stable for over a decade; fluctuating between 9.3 and 9.7 per thousand people, according to Dr. Herman Somers. Dr. Somers pointed up that there have been notable improvements in infant mortality, length of life for females, and excellent control in the remaining infectious diseases. But these gains have been offset by increases in emphysema, lung cancer, cirrhosis of the liver, motor vehicle accidents, suicide, homocide, diabetes mellitus, and cardiovascular disease.

Death rates of young and middle-aged American males are rising sharply and for well defined causes. The leading factors for young men between the ages of 15 and 25 were vehicular accidents, suicide and homocide.

The next group, 25 to 45 — and, we are talking about males — for the same causes, motor vehicular accidents, homocide, suicide, but also lung cancer and cirrhosis of the liver. The latter two diseases related to alcohol and tobacco.

For men between 45 and 65 years, there were substantial increases in death due to emphysema, lung cancer, diseases of the heart and circulatory system, bronchitis and cirrhosis.

It is apparent that the important productive years of American men are being foreshortened, and one can logically infer a marked increase in disability and morbidity resulting from these same causes.

In 1920 the average female baby lived one year longer than the average male baby in this country. But by 1972 the differential was almost eight years between the female and the male baby. And this, of course, explains the increase in widows in our country. Today the average black female baby can expect to live one year longer than the average white male baby born today. The explanation for these facts appears to relate to lifestyles rather than the amount or the availability of medical care.

A study of the relationship between life expectancy and income also has revealed an astounding lack of correlation except among the extremely impoverished people in this country. In other words high income groups who admittedly have better access to medical care have no better health than the middle and lower middle classes in this country. In fact, Dr. Somers found some evidence in his report that their health may be worse than the middle and lower class Americans. Again, the explanation seems to lie in the lifestyle of the affluent rather than the availability of medical care.

Higher incomes have more access and more money for modern medical care, but their health is no better. Perhaps then we should ask ourselves if our lifestyles are not self-destructing, and if in fact many of us are not on a collision course.

What diseases are we talking about? To touch the important ones: Heart and circulatory disease; not only heart attacks but stroke and high blood pressure included in that group. Cirrhosis of the liver; diabetes; emphysema; lung cancer; obesity; suicide and homocide and auto accidents.

And as you study this list, you can see that the causes of death here are largely preventable. But they are not necessarily preventable by dollars or by the construction of a new cancer or stroke facility, but by the health consumer himself. One can also see the clear interrelationship of these diseases and of their causes.

Certainly heart and circulatory disease relate to stress as well as to the use of tobacco and to the excessive use of alcohol. They also relate to obesity and to the diseases of the lung, such as emphysema and bronchitis. Lung cancer, emphysema and bronchitis clearly relate to the use of tobacco. Certainly one cannot deny the relationship of suicide, homocide, and auto accidents to the use of alcohol, and to the tensions which are so common in our 20th century lifestyles and to the

use of drugs. Obesity and lack of exercise seem to be associated with certain of these etiologic factors.

When we speak of the "good life" perhaps we are talking about the consumption of sugar, which now exceeds 125 pounds per American per year, or to the excessive use of alcohol and cigarettes, or to high priced and over-powered automobiles, or to the improper sedentary activities which our affluence seems to engender. Common sense would seem to dictate that we can do something about these diseases. And, self-prevention should be a big educational push for Americans in the coming months.

What changes are we talking about? Cessation of tobacco; reduction of alcoholic intake; maintenance of normal weight, or certainly at least within ten percent of your ideal or normal weight; regular exercise; the avoidance of drugs; the avoidance of excessive tensions and anxieties; proper diet; proper rest and relaxation.

Perhaps with these goals in mind, we could achieve better health for Americans and the time to enjoy that better health.

Time: The bank of life where minutes count. Now if you had a bank that credited you account each morning with $86,400, that carried no balance from day to day allowing you to keep no cash in your account, and finally every evening cancelled whatever part of the amount you had failed to use during the day, what would you do? Draw out every cent, of course.

Well, you have such a bank, and its name is time. Every morning it credits you with 86,400 seconds. Every night it rules off, as loss, whatever of this you have failed to invest to good purpose. It carries no balances. It allows no balances. It allows no over-drafts. Each day the bank, named "time," opens a new account with you. Each night it burns the records of that day. If you fail to use the day's deposits, the loss is yours. There is no going back. There is no drawing against tomorrow. We must live in the present on today's deposits invested so as to get from it the utmost in health, happiness and success.

Reprinted from HRS ACCESS, June-July, 1978.

Dr. Astler is a past president of the Florida Medical Association and the Florida State Board of Medical Examiners. He serves on the editorial advisory committee of the American Hospital Association Journal and is Vice Chairman of the Florida Council of 100 Health Care Committee. This paper was presented before the "Is Your Lifestyle Self-Destructing?" Seminar sponsored by the Florida Council of 100 and Blue Cross-Blue Shield of Florida, September 29, 1977, in Miami.

Florida's Three Medical Schools Grant 337 M.D. Degrees

With traditional pomp and ceremony and exhortations by commencement speakers, Florida's three medical schools conferred Doctor of Medicine degrees on 337 new physicians this spring and thrust them along into the graduate training phase of their medical education.

The University of Miami School of Medicine turned out the largest crop of graduates — 168, including 23 women. The graduating class also included 27 enrolled in a special curriculum for students previously awarded Ph.D. degrees.

Walter C. Jones III, M.D., President-Elect of the Dade County Medical Association, led the graduating class in the recitation of the Oath of Maimonides, which the students consider to be more appropriate in today's world than the better known Oath of Hippocrates.

UM used an in-house commencement speaker, Emanuel M. Papper, M.D., Vice President for Medical Affairs and Dean.

It was Miami's 23rd commencement, and the 1978 graduates swelled the ranks of the school's alumni to 2,026.

At the University of South Florida College of Medicine in Tampa, Harvard Professor Arnold Relman, M.D., Editor of the *New England Journal of Medicine*, lectured 61 graduates on "Reading the Medical Literature." Dr. Relman himself has made substantial contributions to the medical literature as the author of more than 134 articles, books and monographs.

The class included two husband and wife teams and the wives of two members of the Class of 1977.

The South Florida graduates are now scattered in residency programs in 20 states. Eleven plan careers in family practice.

At Gainesville, Theodore Cooper, M.D., Dean of Cornell University's Medical College, spoke the parting words to the 108-member University of Florida College of Medicine graduating class. Eighteen students received special awards for excellence in academic work, clinical performance and medical research.

MEETINGS

Approved by the FMA Committee on Continuing Medical Education

OCTOBER

Current Concepts in Cardiovascular Disease, Oct. 5, Holiday Inn, International Drive, Orlando. For information: George A. Gant, M.D., P.O. Drawer "W", Kissimmee, Florida 32741.

Current Concepts in Neurology, Oct. 12-14, Doral Country Club, Miami. For information: Allan Herskowitz, M.D., 155 Northwest 167th St., North Miami Beach 33169.

10th Annual Joint Meeting of Florida Society of Internal Medicine and American College of Physicians, Oct. 13-15, Breakers Hotel, Palm Beach. For information: Eugene R. Schiff, M.D., Miami.*

Fourth Annual Pan American Seminar, Oct. 16-20, Miami. For information: CME Office, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, Florida 33140.

Post-Graduate Seminar on Occupational Medicine (in Spanish), Oct. 16-20, Key Biscayne Hotel, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Oct. 16-21, Jackson Memorial Hospital, Miami.*

Annual Review Course in Obstetrics and Gynecology, Oct. 21-27, Royal Biscayne Beach Hotel and Racquet Club, Miami.*

10th Inter-American Conference on Toxicology and Occupational Medicine, Oct. 22-25, Key Biscayne Hotel, Miami.*

Laparoscopy Course, Oct. 25-26, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

OB-GYN Pathology Course, Oct. 27-28, Royal Biscayne Hotel and Racquet Club, Miami.*

Emergencies in Internal Medicine, Oct. 31-Nov. 4, Caribe Hilton Hotel, San Juan, P.R.*

NOVEMBER

Thromboembolism and Thrombolytic Therapy, How-When-and Why, Nov. 2, Mount Sinai Medical Center, Miami Beach. For information: CME Office, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, Florida 33140.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Nov. 6-11, Jackson Memorial Hospital, Miami.*

***For information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

Medicine in Maturity (Geriatric Medicine), Nov. 8-12, Don CeSar Hotel, St. Petersburg Beach. For information: American Medical Women's Association, 1740 Broadway, New York, New York 10019.

Current Topics in Perinatology, Nov. 11-18, Caribbean Cruise.*

Adolescent Medicine, Nov. 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Clinical Family Planning for Physicians, Nov. 13-14, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Laparoscopy Course, Nov. 13-14, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Medical Aspects of Aging, Nov. 17-18, Gainesville Hilton, Gainesville.**

Fracture Bracing,Nov. 17-19, location to be announced.*

Florida Endocrine Society's Fall Meeting, Nov. 18-19, The Colony Beach & Tennis Resort, Sarasota. For information: Yank D. Coble Jr., M.D., 2700 Riverside Avenue, Jacksonville 32205.

DECEMBER

7th Annual Refresher Course for Nurse Anesthetists, Dec. 1-3, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

8th Family Practice Review, Dec. 4-8, Candada Beach/LaConcha Convention Center, San Juan, P.R. For information: Bill Rockwood, Gainesville.**

Echocardiography In-Service Workshop, Dec. 4-8, Jackson Memorial Hospital, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Dec. 4-9, Jackson Memorial Hospital, Miami.*

Neuro-Ophthalmology, Dec. 6-9, Key Biscayne Hotel, Miami.*

Glaucoma Symposium, Dec. 7-9, University of South Florida Medical Center, Tampa. For information: W. E. Layden, M.D., P.O. Box 21, MDC, University of South Florida, Tampa 33612.

Orthotics and Prosthetics, Dec. 7-10, Americana Hotel, Miami Beach.*

Hand Surgery, Dec. 8-9, Americana Hotel, Miami Beach.*

Cardiac Symptoms and Arrhythmias — Their Diagnosis and Treatment, Dec. 8-10, Americana of Bal Harbour, Miami. For information: IMEC, 64 Inverness Drive East, Englewood Colorado 80110.

Coronary Disease, Exercise Testing, and Cardiac Rehabilitation, Dec. 8-10, Konover Hotel, Miami. For information: IMEC, 64 Inverness Drive East, Englewood, Colorado 80110.

Vaginal Surgery Seminar, Dec. 10-16, Royal Biscayne Hotel & Racquet Club, Miami.*

Laparoscopy Course, Dec. 11-12, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

JANUARY

2nd Annual Oral Pathology Review, Jan. 8-12, Jackson Memorial Hospital, Miami.*

Art and Science in Therapy of Difficult Problems in Surgery, Jan. 10-13, Americana Hotel, Miami Beach.*

Postgraduate Seminar in Pediatric and Adult Urology, Jan. 10-13, Carillon Hotel, Miami Beach. For information: Victor Politano, M.D., 6614 Miami Lakes Drive, East Miami Lakes 33014 or phone (305) 822-6000.

Annual Seminar in Otolaryngology, Jan. 15-18, Doral Country Club and Hotel, Miami Beach.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Jan. 15-20, Jackson Memorial Hospital, Miami.*

Miami Winter Symposia, Jan. 22-28, Intercontinental Hotel, Miami.*

4th Annual Review and Recent Practical Advances in Pathology, Jan. 23-26, Konover Hotel.*

Winter Conference on Principles of Practice Management, Jan. 27-Feb. 3, Lion Square Lodge, Vail, Colorado.*

Vail Conference in Intensive Care, Jan. 27-Feb. 3, The Mark Resort, Vail, Colorado.*

Laparoscopy Course, Jan. 29-30, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

A Neurological Update 1979, Jan. 29-Feb. 3, Konover Hotel, Miami.*

FEBRUARY

24th Central Florida Medical Meeting, Feb. 1-4, Contemporary Resort Hotel, Lake Buena Vista, Florida. For information: Sam F. Elder, M.D., 601 Rollins Avenue, Orlando 32803.

Second Symposium on Neurological Surgery of the Ear, Feb. 3-8, Sarasota. For information: Ms. Susan G. Brown, 1845 Hillview Street, Sarasota 33579.

Fifth Annual Vail Conference in Anesthesiology, Feb. 3-10, The Mark Resort, Vail, Colorado.*

Obstetrical and Gynecological Ultrasound In-Service Workshop, Feb. 5-9, Jackson Memorial Hospital, Miami.*

Florida Midwinter Seminar in Ophthalmology and Otolaryngology, Feb. 5-10, Americana Hotel, Miami Beach.*

Imageology 1979, Feb. 16-23, Konover Hotel, Miami Beach. For information: Mrs. Lucy E. Kelley, c/o Medical Seminars, P.O. Box 343762, Coral Gables 33134.

6th Annual Pediatric Dermatology Seminar, Feb. 17-25, M/V Buccaneer, Galapagos Islands. For information: Guinter Kahn, M.D., 16800 Northwest 2nd Avenue, Suite 401, North Miami Beach, Florida 33169.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Feb. 19-24, Jackson Memorial Hospital, Miami.*

Management of the Tiny Baby — 1979, Feb. 22-23, Dutch Inn, Lake Buena Vista. For information: Keith S. Kanarek, M.D., 1416 South Orange Avenue, Orlando, Florida 32806.

OB-GYN Cruise Seminar, Feb. 24-Mar. 6. (Cruise line to be announced).*

12th Pan American Congress of Ophthalmology, Feb. 25-Mar. 2, Fontainebleau Hotel, Miami Beach.*

Laparoscopy Course, Feb. 26-27, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Basic Neurology for Psychiatrists, Family Practitioners and General Practitioners, Feb. 26-Mar. 2, Konover Hotel, Miami.*

Teaching Conference in Clinical Cardiology, Feb. 28-Mar. 3, Americana Hotel, Miami Beach.*

MARCH

Gynecologic Endocrinology and Infertility, Mar. 1-3, Orlando Hyatt House, Orlando. For information: Bernard Cantor, M.D., Gainesville.**

Medical Imaging 1979, Mar. 8-10, Royal Biscayne Hotel, Miami.*

Medical Hypnosis and Short-Term Psychotherapy, Mar. 10-14, Americana Hotel, Miami Beach.*

Current Trends in Radioimmunoassay 1979, Mar. 11-13, Royal Biscayne Hotel, Miami.*

American and European Views on Anesthesiology, Mar. 24-31, Zermatt, Switzerland.*

Laparoscopy Course, Mar. 26-27, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

APRIL

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 9-14, Jackson Memorial Hospital, Miami.*

Laparoscopy Course, Apr. 23-24, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Seventh Annual Surgical Intensive Care Symposium, Apr. 27-30 (location to be announced).*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 30-May 5, Jackson Memorial Hospital, Miami.*

MAY

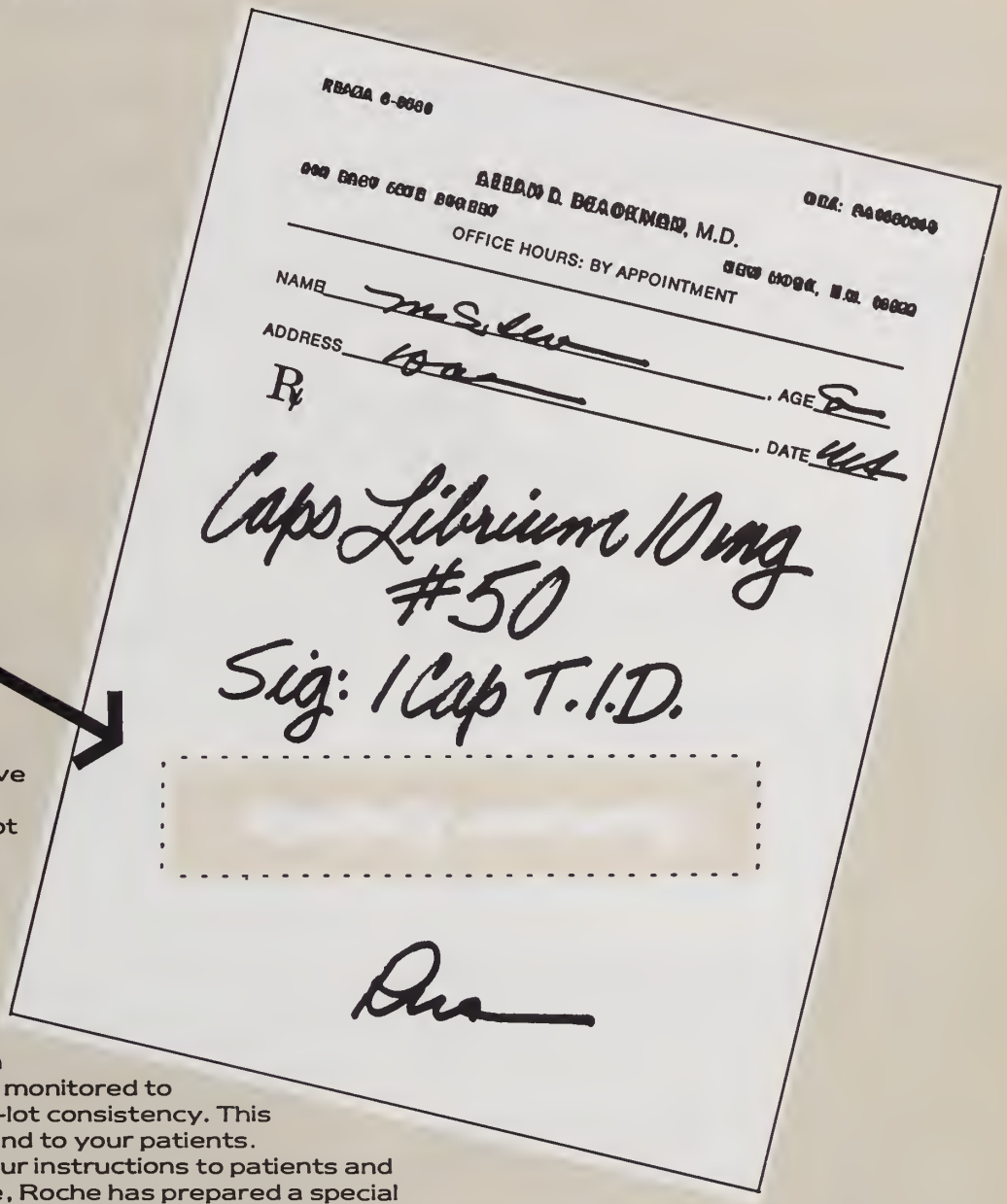
Ultrasound (General) In-Service Workshop, May 7-11, Jackson Memorial Hospital, Miami.**

JUNE

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

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Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack



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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enter bacteriaceae* in the bowel without the emergence of res tant organisms. Thus, Bactrim reduces the risk of intro colonization by fecal uropathogens. It has *no* signifi- cant effect on other normal, necessary intestinal flora.

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Bactr in the urinary trac estinal trac

Please see reverse side for summary of product information.

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OCTOBER 1978 • VOL 65 • NO 10

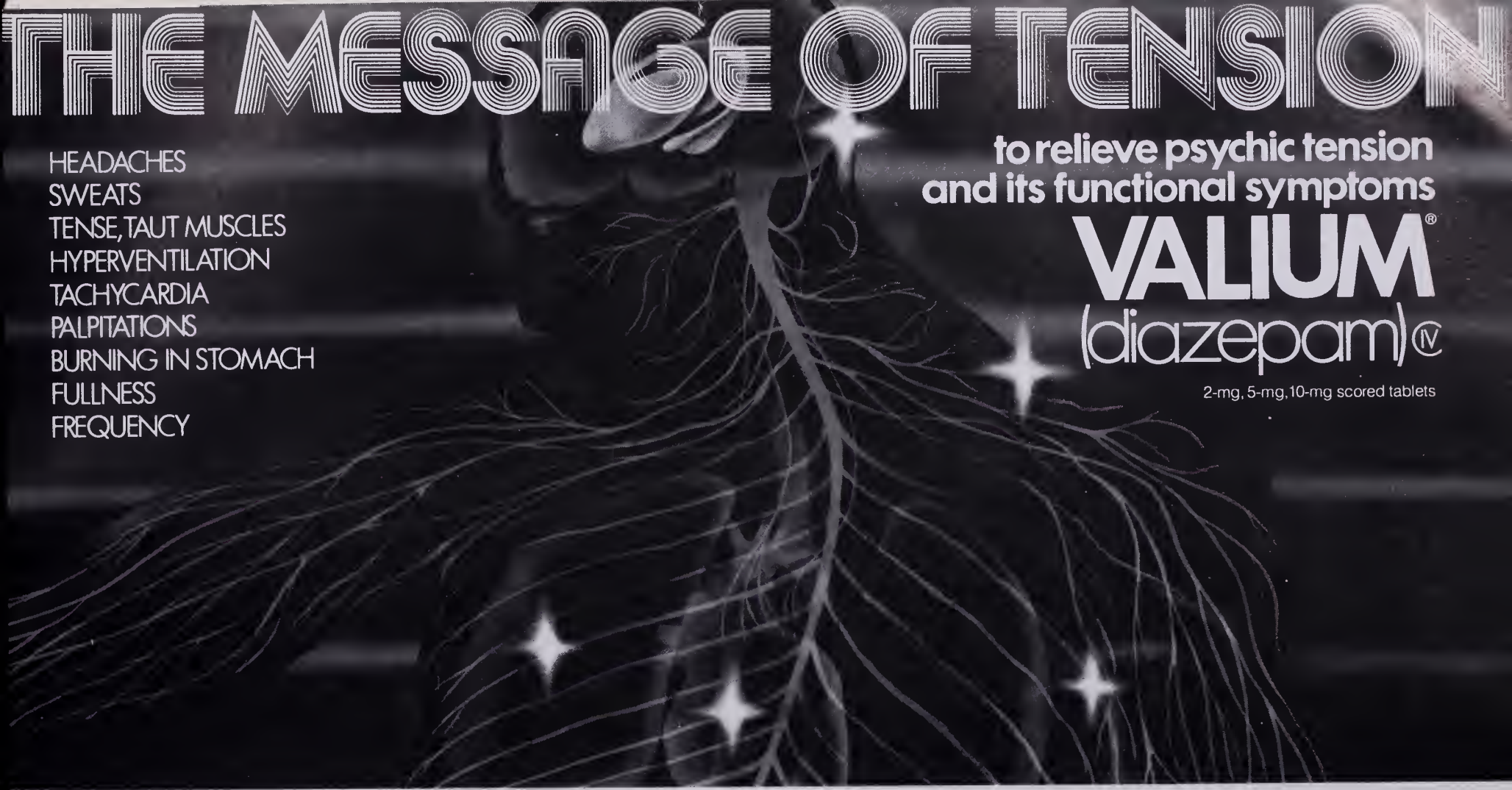


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Know Your Board of Governors, page 837

Vote "For"
Constitutional Revision #1
Separate Department of Health
See pages 802a and 835



VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Nature just doesn't make a perfect food.

No one food supplies all the nutrients children need.

But milk supplies more essential nutrients per calorie than most other foods.

A child between the ages of six months and six years, for example, can get at least three-fourths of his daily dietary allowance for calcium, riboflavin, vitamins D and B_{12}, phosphorous, and protein from just three glasses of milk. And milk is also a good source of vitamins A and B_6, as well as thiamin and niacin (please see chart).

That's why the U.S.D.A., acting on the recommendation of the National Research Council—National Academy of Sciences, has established these guidelines for milk consumption:

Children up to 6 years
Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.–1 yr.	1 yr.–3 yrs.	3 yrs.–6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on: 60 mg tryptophan=1 mg niacin

ndc **National Dairy Council**

Milk. Sometimes we forget all the good things it does.

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OCTOBER 1978 • VOL 65 • NO 10

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OCTOBER COVER — A Spanish drawing by Pablo Picasso, 1904. Courtesy of the Fogg Art Museum, Harvard University, Cambridge.

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Brief Summary of Prescribing Information

Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

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- two dosage forms: Tablets and Suspension—suitable for the entire family

Povan—there's a form for every member of the family.

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Detroit, Michigan 48232



President's Page

Constitution Revision #1
A Separate Department of Health

As physicians, we are all concerned with providing the highest quality medical care for our patients and for the betterment of the public health for the benefit of all Floridians.

Prior to revision of Florida's Constitution in 1969, Florida was recognized as having one of the nation's leading public health systems. With removal of a mandate for a separate department from the Constitution, Florida's public health system is for all practical purposes non-existent. Our public health officer has been reduced to a fourth level advisor within the massive Department of HRS with no direct-line authority to deal effectively with critical public health problems.

The 1977 Constitution Revision Commission, in its wisdom, voted overwhelmingly to include a mandate for reestablishing a separate Department of Health in its proposed revision to Florida's Constitution. Revision #1, when approved by the voters on November 7th will accomplish this goal.

Voter approval of Revision #1 cannot be assured without the **active, individual support of physicians at the local level.** Because of certain legal restraints relative to so-called "grassroots lobbying," activity of the Florida Medical Association in support of Revision #1 must be limited to education of the Association membership. The favorable tax exempt status presently enjoyed by the FMA would possibly be jeopardized if we engaged in appeals to the general public for support of Revision #1 which contains the provision for the separate Department of Health. **This makes our active, individual participation crucial.** When you are called upon by fellow physicians in your community to help gain public support for the separate Department, please respond with your greatest and most intense enthusiasm.

With your help, approval of Revision #1 can be assured which will put health care back into the hands of qualified physicians and restore Florida's public health program to national prominence.

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

URGENT NOTICE

Standardized Health Claim Form — The 1977 Florida Legislature Enacted FS Chapter 77-46 Requiring The Department of Insurance to Prescribe a Standard Health Form to be Used by all Hospitals and a Standard Health Claim Form to be Used by all Physicians.

EXCERPT FROM
FLORIDA MEDICAL ASSOCIATION, INC'S
BRIEF NO. 258, JUNE 27, 1978
FURTHER
THE AMA'S JUDICIAL COUNCIL'S
OPINIONS AND REPORTS, PAGE 16, PARAGRAPH 4.30

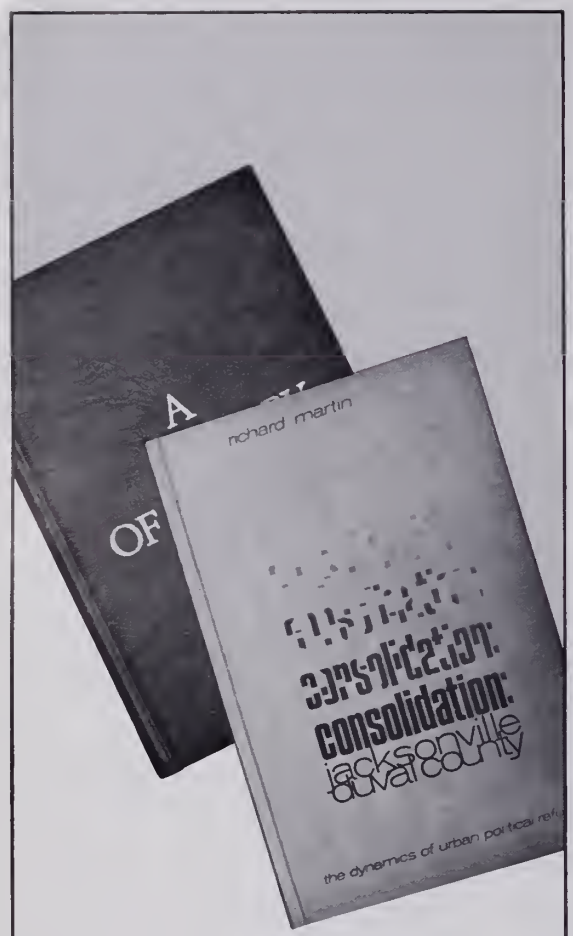
> **"4.30. INSURANCE FORM COMPLETION CHARGE**
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Tenuate® ⓡ
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence.* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633
Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

8-3921 (Y587A)

Whether overweight is a complicating factor... or just uncomplicated overweight.

Tenuate® Dospan® (IV)

(diethylpropion hydrochloride NF)

75 mg. controlled-release tablets



A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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Now in its second year, the Medical Necessity Program has been changed and modified, with questionable procedures now divided into three categories:

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Dean's Page

Nondiscrimination on the Basis of Handicap

Hollis G. Boren, M.D.

On May 4, 1977, Health, Education and Welfare's Office of Civil Rights published in the Federal Register the final regulations for implementing Section 504 of the amended Rehabilitation Act of 1973. This act calls for sweeping changes in accommodations of facilities to provide access and equal opportunity for qualified handicapped persons on campuses. Less well known is the fact that the Act also contains some of the most restrictive and unacceptable regulations relating to the admissions process and curriculum of medical schools yet devised.

Our medical schools continue to be besieged with a continual flow of such new regulations. We have had to provide assurances that we will comply with the arbitrarily assigned percent of "primary care" residencies by the Bureau of Health Manpower. On October 1, 1978, Section 227 of Public Law 92-063 of the Social Security Administration regarding the reimbursement of physicians in a teaching setting is to be implemented. This section, in the opinion of many Deans, threatens the existence of academic health centers as we have known them. As we consider Section 504, I do not believe that many members of the FMA can doubt that the continuing efforts on many fronts of the federal establishment forecasts many ills for medical education and practice.

The regulations of Section 504 start with the usual threat. Recipients of federal financial aid through any instrumentality either directly or indirectly must comply. The selected definition of a handicapped person is extremely broad. By Section 504 a handicapped person is someone who has physical or mental impairment which substantially limits one or more life activities, such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. Drug addicts and alcoholics are handicapped for the purposes of Section 504. The first consequence of these regulations is that the question "Do you have or have had any chronic or recurrent illnesses, emotional problems, or bodily defects?" can no longer be asked! Will it be very long before we are reduced to asking only "name, rank and serial number"?

A great deal of ambiguity was left in the regulations by the use of the terms "academic" and "technical" standards for admission to medical schools. Technical criteria for admissions were not defined. The regulations refer to "qualified" handicapped persons. The argument is already being made that a blind or a deaf person may be technically qualified for admission to medical school, since a blind student has graduated from one medical school, and might conceivably function in some area of medicine such as research. The same government which is willing to accept a blind, deaf or dumb applicant for research says that the number of physicians who can practice Surgery, Ob/Gyn or Psychiatry must be limited because they are not "primary care areas".

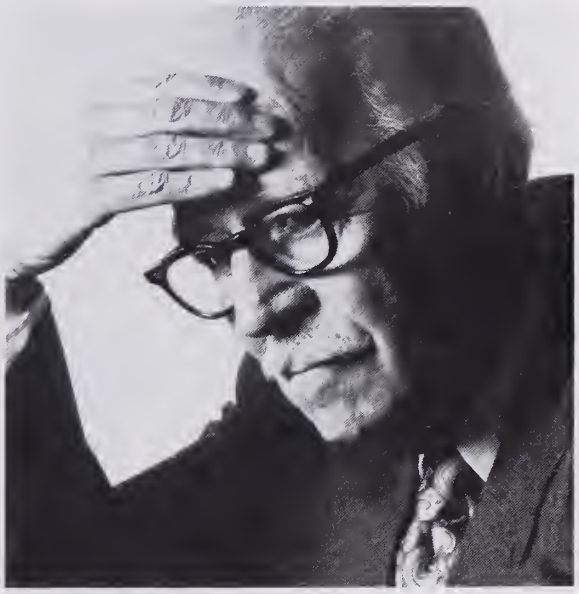
In answer to the impossibility of such severely handicapped persons to take many parts of the medical curriculum, Health, Education and Welfare already has its answer. A determination as to what are essential and what are required courses will be made. By whom shall such decisions be made? By HEW, of course, and not by the schools or professional educators involved in the job of training the best possible physicians.

Such is the situation as we begin the 1978 academic year. The banner "handicapped" has the role of motherhood, God and apple pie. It covers the further invasion of HEW into medical education. The false hopes and the placing of our unfortunate handicapped in impossible situations does not seem to bother the proponents of such regulations. To them it does not seem to matter how many people are hurt or how many funds are wasted. There certainly is no cost containment in their war chest.

Dr. Boren is Director of the University of South Florida Medical Center and Dean of the College of Medicine, Tampa.

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INDICATIONS: Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

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1. Shane, S.J.: Canadian Family Physician, November 1973. 2. Lemberg, L.: Practical Cardiology, February 1976.

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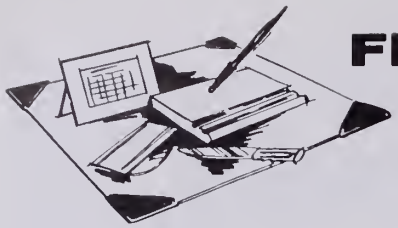
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FROM THE EDITOR'S DESK

WAGE-PRICE COUNCIL DISPUTED

A new study disputes claims of the President's Council on Wage and Price Stability that medical doctors are able to set "target incomes" and adjust their fees to meet them. Since 1970, according to Professor Keith B. Leffler, a University of Washington economist, physicians' earnings in this country have not kept pace with increases in the cost of living. Physicians' earnings, he reports in "Explanations in Search of Facts: A Critique of 'A Study of Physicians' Fees," are influenced by such factors as numbers of physicians, median family income, population, and the proportion of expenditures on physicians' services that consumers pay out of pocket. Professor Leffler's study was published by the Law and Economics Center of the University of Miami School of Law.

* * * * *

COST OF LIVING

HEW Secretary Joseph Califano apparently didn't have the latest facts when he told newsmen in July that health care costs are rising faster than the general cost of living. Only the day before the Bureau of Labor Statistics reported a one per cent rise for June in the all-items index of the Consumer Price Index, compared with a half per cent increase in the medical care index.

* * * * *

REGULATION CONTESTED

The Department of HEW proposes to require that the boards and committees of Medicare and Medicaid carriers, intermediaries and fiscal agents have public majorities. The proposal would also require the states to mandate public majorities on the boards of Medicaid fiscal agents. HEW says it is concerned that the influence of persons with a financial interest in health care delivery "may" compromise the carrier and agents. The AMA objected and said the proposal is "based on the false notion that by the mere fact of being a member of the medical profession one would be motivated by self-interest to oppose cost effective health care."

HOSPITAL COSTS

The Joint Commission on Accreditation of Hospitals has pledged to continue to do what it can to help control hospital costs. The Board of Commissioners aid JCAH would "continue to promulgate standards that enhance cost effectiveness through the control of practices and settings that minimize risk to both patients and personnel." Also, JCAH will continue efforts "to reduce the duplicative surveys and inspections that health care institutions are subjected to and that impose a financial burden without significantly improving the quality of care.

* * * * *

DRUG PRICE CATALOG

The AMA has pointed out some inadequacies in the drug price catalog that the Department of HEW plans to publish. HEW Secretary Joseph Califano said the *Guide to Drug Prices*, scheduled for publication in January, "should allow doctors and pharmacists to take costs into account when prescribing and ordering prescription drugs." AMA pointed out that the listed prices are national averages and the lowest priced drug may be the highest in a particular area or pharmacy. AMA recommends additional study to determine the correlation of pharmacy acquisition costs with retail prices, and the relationship of pharmacy location and acquisition costs.

* * * * *

MEDICARE INCREASE

An annual cost of living review has led to a five per cent increase in physicians' Medicare reimbursement rates, retroactive to July 1. The increase is expected to amount to $1.4 billion over one year. The increase was preceded by an announcement by HEW Secretary Jeseph Califano that the government will limit Medicare and Medicaid payments for laboratory services and medical equipment to their lowest locally available prices.

GOVERNORS LOBBIED

Sen. Edward Kennedy and White House staffers showed up at the Annual Meeting of the National Governors Association in August to lobby for their National Health Insurance programs. But cost-conscious governors, with the tax revolt in California fresh in their minds, appeared in no mood to endorse any such plan. Kennedy warned that the failures of the health care system could ignite a rebellion more serious than the tax revolt. Administration representative told the governors that Kennedy's plan is too sweeping to have any chance in Congress.

* * * * *

COINSURANCE AND DEDUCTIBLES

Physicians who customarily make no attempt to collect coinsurance or deductibles from Medicare patients may find their actual and customary charges reduced by carriers. According to the Medicare Carriers Manual, carriers are instructed to review such cases and process claims on the basis of the amounts the physicians actually expect to receive. These amounts will be used in updating customary charge screens.

* * * * *

BLUES

The Blue Cross and Blue Shield Associations have undertaken a three-year plan aimed at improving their share of the health insurance market. A Blues official said the priority recommendation is a redesigned national master contract, with serious consideration to be given to cost-sharing features. Other goals include: cost-effective claim and inquiry processing; a competitive pricing system; a national management information and reporting system; a national management strategy and plan; effective marketing programs; and national programs to moderate cost trends and measure cost-control effectiveness.

* * * * *

PHYSICIAN SURVEY

The AMA's Center for Health Services Research and Development is conducting its 12th annual survey of physicians. The study is undertaken to provide current and reliable information on the practice of medicine. Survey results are published each year in **Profile of Medical Practice.** The random sample consists of 10,000 non-federal physicians. In addition, 2,500 women MDs and 4,500 rural physicians will be polled.

INFLATION

The President of the U.S. Chamber of Commerce has warned that further government involvement in health care will trigger more inflation. President Richard L. Lesher recalled that the first year of Medicare was estimated to cost $1.4 billion, but the final figure was $3.5 billion. He estimated Medicare will cost $30 billion by 1980 and warned that the same thing will happen if National Health Insurance is enacted.

* * * * *

VISIT WITH PRESIDENT

An AMA Delegation headed by President Tom E. Nesbitt, M.D., met with President Carter and some of his aides at the White House on July 26. National health issues were discussed. It was reported that President Carter is willing to meet further with AMA leaders on broad matters of health interest.

* * * * *

FTC CHALLENGED

The states of Indiana, Kentucky, Nebraska, Oklahoma, Texas and Wyoming are taking the Federal Trade Commission to court. They are challenging FTC's authority to preempt state laws restricting the advertising of prices for eyeglasses and eye examinations. At issue is whether congressional authority to override state laws can be extended to federal agencies.

* * * * *

ADMINISTRATIVE SUBPOENAS

A federal appeals court in Washington, D.C., has held the government should pay some of the costs of complying with administrative subpoenas issued by federal agencies. But the court said those subpoenaed are obligated to absorb "reasonable expenses of compliance." The ruling came in a suit filed by Arthur Young and Company involving an "unduly burdensome" subpoena issued by the Securities and Exchange Commission.

The Editor

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Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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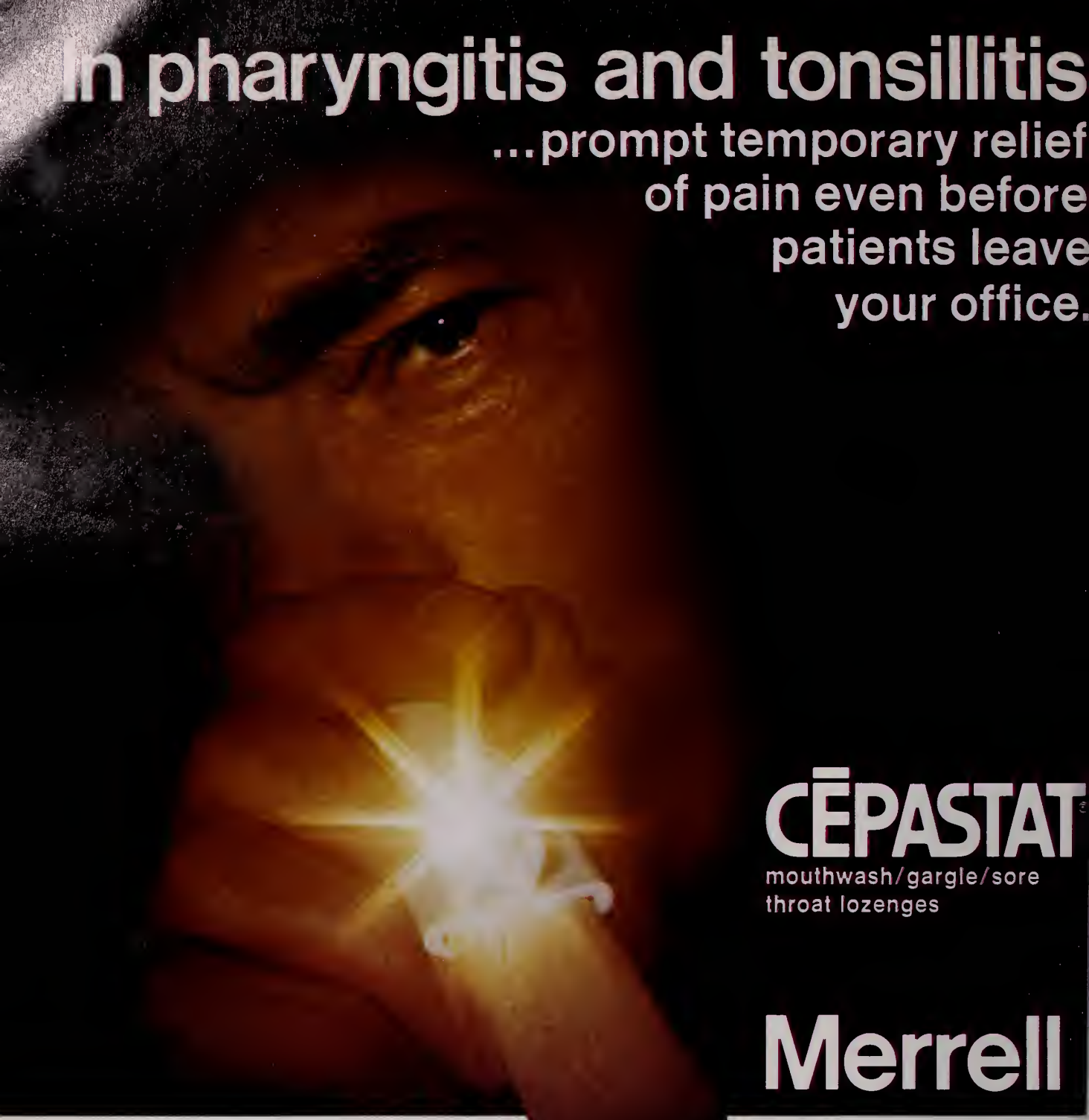
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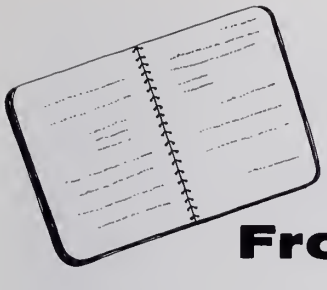
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From the Student's Notebook

by Jerrold A. Van Dyke

The medical students asked to participate on the editorial board of *The Journal* have had a unique opportunity within organized medicine. From this vantage point we can learn first hand about the Florida Medical Association and why a strong organization is so necessary at this time with the current medico-legal climate and the recurring threat of intervention and interference.

Having grown up during the upheavals of the sixties and early seventies, I was constantly bombarded with propaganda that was "anti-everything" which is "organized and established." I continually heard how formidable the American Medical Association could be. At that time, I vowed never to become a part of that "evil force."

Having always considered myself as an individual who was politically apathetic, and as one who would rather avoid anything "organized," it was with a great deal of reservation that I accepted a chance to join the editorial staff of *The Journal*. Since then, my attitude has changed drastically.

Medical student input into the decision-making processes of *The Journal* helped make it possible to distribute to all medical students in the state a copy of the March issue of *The Journal* on poisonous plants in Florida. If this particular issue was valuable, then every future physician should have access to it. Furthermore, it was a positive reinforcement for the medical student editors to participate in an adventure of potential value to so many citizens.

The involved medical students should heartily thank the FMA for the opportunity to really participate in a meaningful fashion. The three medical students representing each of the state's three medical schools have once again been given the opportunity to participate in another unique way. We have been given a page in *The Journal* so that we might share with our readers our thoughts about medicine.

Our intentions will include the reporting of exciting new ideas and research projects that are going on in our respective institutions. This will be our goal each month. It should be interesting to see how this new page evolves. This page also should be a forum in which a medical student's perspective of medicine might be presented even though at times this viewpoint will seem naive to the experienced clinician.

Finally, thank you for giving us this special opportunity. My personal participation with the staff and editors of the Journal has been an extraordinary experience. I have come to appreciate the need for an organized and systematic approach to the evolution of health care in this country. To contend with today's powerful forces within the government and the legal profession, only a consolidated and organized approach will enable doctors to be in a position to continue to deliver the best care to their patients. Political apathy and lack of knowledge about the important issues will only invite disaster for our profession. We appreciate the various members of the FMA who have taught us, fledglings in the field of medicine, these important lessons.

Mr. Van Dyke is a fourth year medical student at the University of Florida College of Medicine, and an Assistant Editor of the Journal.

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FMA AUXILIARY

Auxiliary Benefit Art Show Awards

A wide variety of interesting works was presented at the Twelfth Annual Auxiliary Benefit Art Show, held in cooperation with the Annual Meeting of the Florida Medical Association, May 3-6, in Hollywood.

The many talented physicians and their family members provided us with an "aesthetic holiday" amidst the convention background.

The art show awards presented were as follows:

PAINTINGS:
First Place — Carol M. Dan (Mrs. Lewis R.), Miami Shores — "Patio"
Second Place — Beverly Farrior, Tampa — "Gulf at Evening"

PHOTOGRAPHY
Best in Show — C. H. Brown III, M.D., Orlando — "Nude Study"
Editor's Award — Eric F. Geiger, M.D., Pensacola — "Bright Reflections"

GRAPHICS:
First Place — Clarence M. Gilbert, M.D., Orlando — "Castle Arches"
Second Place — Carol M. Dan (Mrs. Lewis R.), Miami Shores — "Forest Geometry"

CRAFTS:
First Place — Judd Bockner, M.D., Boca Raton — Alabaster Head
Second Place — Raymond J. Fitzpatrick, M.D., Gainesville — Womens Lib

MERIT AWARDS:
Acrylic by Mary Roberson, age ten, West Palm Beach
"Jackie" by Toni Charneco (Mrs. Dale R.), Jacksonville — charcoal
"Florida Sunset" by John Tignor, age 14 (son of Milton R. Tignor, M.D.), West Palm Beach — Photography
"Quiet Water" by Eric F. Geiger, M.D., Pensacola — Photography
"Sand Storm in Grand Canyon" by Buff Matthews (Mrs. Joseph G.), Orlando — Photography
"Day Lillies" by Elly Holzberg (Mrs. Donald J.), Miami Beach

Funds raised by the exhibit this year went into the FMA Auxiliary Research Foundation. We look forward to an exciting display next year.

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This plan helps protect your income by providing benefits up to $1,950 a month if you can't practice medicine due to a covered accident or illness. Open to all FMA members under age 60 who meet the underwriting requirements of the plan.

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This plan provides up to $150,000 for accidental death or dismemberment. ACCEPTANCE IS GUARANTEED for all FMA members and their spouses under age 60.

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Each yellow tablet contains 1 mg norethindrone and 0.05 mg mestranol.
Each green tablet in the 28-day regimen contains inert ingredients.

§Serious as well as minor side effects have been reported with the use of oral contraceptives. These include thromboembolic disease. The physician should remain alert to the earliest manifestations of any symptoms of serious disease and discontinue oral contraceptive therapy when appropriate. The physician should be fully aware of the complete Prescribing Information for this product.

See the complete Prescribing Information for this product, a summary of which is on the next page.

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OP 1291

ORTHO-NOVUM* Tablets

PACKAGE INSERT NOTE—This information is a BRIEF SUMMARY of the complete prescribing information provided with the product and therefore should not be used as the basis for prescribing the product. This summary was prepared by deleting from the complete prescribing information certain text, tables, and references. The physician should be thoroughly familiar with the complete prescribing information and patient information before prescribing the product.

INDICATION: CONTRACEPTION. The pregnancy rate in women using conventional combination oral contraceptives (containing 35 mcg or more of ethinyl estradiol or 50 mcg or more of mestranol) is generally reported as less than one pregnancy per 100 woman-years of use. Slightly higher rates (somewhat more than one pregnancy per 100 woman-years of use) are reported for some combination products containing 35 mcg or less of ethinyl estradiol, and rates on the order of three pregnancies per 100 woman-years are reported for the progestogen-only oral contraceptives. Table 1 gives ranges of pregnancy rates reported in the literature for other means of contraception. The efficacy of these means of contraception (except the IUD) depends upon the degree of adherence to the method.

Table 1: Pregnancies Per 100 Women-Years. IUO, less than 1-6; Diaphragm with spermicidal product (creams or jellies), 2-20; Condom, 3-36; Aerosol foams, 2-29; Jellies and creams, 4-36; Periodic abstinence (rhythm) all types, less than 1-47; 1. Calendar method, 14-47; 2. Temperature method, 1-20; 3. Temperature method—intercourse only in postovulatory phase, less than 1-7; 4. Mucus method, 1-25; No contraception, 60-80. **DOSE-RELATED RISK OF THROMBOEMBOLISM FROM ORAL CONTRACEPTIVES:** Two studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. For this reason, it is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive product prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance. It is recommended that new acceptors of oral contraceptives be started on preparations containing .05 mg or less of estrogen.

CONTRAINDICATIONS: Oral contraceptives should not be used in women with any of the following conditions: 1. Thrombophlebitis or thromboembolic disorders. 2. A past history of deep vein thrombophlebitis or thromboembolic disorders. 3. Cerebral vascular or coronary artery disease. 4. Known or suspected carcinoma of the breast. 5. Known or suspected estrogen-dependent neoplasia. 6. Undiagnosed, abnormal genital bleeding. 7. Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. THROMBOEMBOLIC OISORDERS ANO OTHER VASCULAR PROBLEMS. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic. These studies estimate that users of oral contraceptives are 4 to 11 times more likely than nonusers to develop these diseases without evident cause. Overall excess mortality due to pulmonary embolism or stroke is on the order of 1.0 to 3.5 deaths annually per 100,000 users and increases with age. **CEREBROVASCULAR DISORDERS:** In a collaborative American study of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than in nonusers and the risk of thrombotic stroke was 4.0 to 9.5 times greater in users than in nonusers.

MYOCARDIAL INFARCTION: An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported confirming a previously suspected association. These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor. The annual excess case rate (increased risk) of myocardial infarction (fatal and nonfatal) in oral contraceptive users was estimated to be approximately 7 cases per 100,000 women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group. In terms of relative risk, it has been estimated that oral contraceptive users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are also smokers have about a 5-fold increased risk of fatal infarction compared to users who do not smoke, but about a 10-to 12-fold increased risk compared to nonusers who do not smoke. Furthermore, the amount of smoking is also an important factor. In determining the importance of these relative risks, however, the baseline rates for various age groups must be given serious consideration. The importance of other predisposing conditions mentioned above in determining relative and absolute risks has not as yet been quantified; it is quite likely that the same synergistic action exists, but perhaps to a lesser extent. **Risk of Dose:** In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives. Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 50-80 mcg of estrogen. Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved. This finding has been confirmed in the United States. Careful epidemiological studies to determine the degree of thromboembolic risk associated with progestogen-only oral contraceptives have not been performed. Cases of thromboembolic disease have been reported in women using these products, and they should not be presumed to be free of excess risk. The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age. Oral contraceptives are, however, an independent risk factor for these events. **ESTIMATE OF EXCESS MORTALITY FROM CIRCULATORY DISEASES:** A large prospective study carried out in the United Kingdom estimated the mortality rate per 100,000 women per year from diseases of the circulatory system for users and nonusers of oral contraceptives according to age, smoking habits, and duration of use. The overall excess death rate annually from circulatory diseases for oral contraceptive users was estimated to be 20 per 100,000 (ages 15-34—5/100,000; ages 35-44—33/100,000; ages 45-49—140/100,000), the risk being concentrated in older women, in those with a long duration of use, and in cigarette smokers. It was not possible, however, to examine the interrelationships of age, smoking, and duration of use, nor to compare the effects of continuous versus intermittent use. Although the study showed a 10-fold increase in death due to circulatory diseases in users for five or more years, all of these deaths occurred in women 35 or older. Until larger numbers of women under 35 with continuous use for five or more years are available, it is not possible to assess the magnitude of the relative risk for this younger age group. This study reports that the increased risk of circulatory diseases may persist after the pill is discontinued. Another study published at the same time confirms a previously reported increase of mortality in pill users from cardiovascular disease. The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception. The estimates of risk of death for each method include the combined risk of the contraceptive method (e.g., thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure. This latter risk varies with the effectiveness of the contraceptive method. The findings of this analysis are shown in Figure 1 below. The study concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke. (The rates given for pill only/smokers for each age group are for smokers as a class. For "heavy" smokers [more than 15 cigarettes a day], the rates given would be about double; for "light" smokers [less than 15 cigarettes a day], about 50 percent.) The mortality associated with oral contraceptive use in nonsmokers over 40 is higher than with any other method of contraception in that age group. The lowest mortality is associated with the condom or diaphragm backed up by early abortion. The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia and especially by cigarette smoking. The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors. The use of oral contraceptives in women in this age group is not recommended. Based on the data currently available, the following chart gives a gross estimate of the risk of death from circulatory disorders associated with the use of oral contraceptives:

SMOKING HABITS ANO OTHER PREDISPOSING CONOITIONS—RISK ASSOCIATED WITH USE OF ORAL CONTRACEPTIVES

Age	Below 30	30-39	40+	
Heavy smokers	C	B	A	A—Use associated with very high risk.
Light smokers	0	C	B	B—Use associated with high risk.
Nonsmokers (no predisposing conditions)	0	C,O	C	C—Use associated with moderate risk.
Nonsmokers (other predisposing conditions)	C	C,B	B,A	0—Use associated with low risk.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e.g., thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately. A four- to six-fold increased risk of postsurgery thromboembolic complications has been reported in oral contraceptive users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization. 2. OCULAR LESIONS. There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives. Oiscontinue oral contraceptive medication if there is unexplained, sudden or gradual, pártial or complete loss of vision; onset of proptosis or diplopia; papilledema; or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures. 3. CARCINOMA. Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver. Certain synthetic progestogens, none currently contained in oral contraceptives, have been noted to increase the incidence of mammary nodules, benign and malignant, in dogs. In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives. Of the cases found in women without predisposing risk factors for adenocarcinoma of the endometrium (e.g., irregular bleeding at the time oral contraceptives were first given, polycystic ovaries), nearly all occurred in women who had used a sequential oral contraceptive. These products are no longer marketed. No evidence has been reported suggesting an increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives. Several studies have found no increases in breast cancer in women taking oral contraceptives or estrogens. One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in the subgroups of oral contraceptive users with documented benign breast disease. A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented. In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of alf women taking oral contraceptives is, nevertheless, essential. In all cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures shoufd be taken to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception.

Figure 1. Estimated annual number of deaths associated with control of fertility and no control per 100,000 nonsterile women, by regimen of control and age of woman.

	15-19	20-24	25-29	30-34	35-39	40-44
No method	5.5	5.2	7.1	14.0	19.3	21.9
Abortion only	2.3	2.5	2.5	5.2	9.8	6.6
Pill only-nonsmokers	1.3	1.4	1.4	2.2	4.5	3.1
Pill only-smokers	1.5	1.6	1.6	10.8	13.4	58.9
IUOs only	1.1	1.2	1.2	1.4	1.6	1.4
Traditional contraception only	1.1	1.4	1.9	3.7	4.7	4.0
Traditional contraception and abortion	0.3	0.4	0.4	0.8	1.4	0.8

4. HEPATIC TUMORS. Benign hepatic adenomas have been found to be associated with the use of oral contraceptives. One study showed that oral contraceptive formulations with high hormonal potency were associated with a higher risk than lower potency formulations. Although benign, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage. This has been reported in short-term as well as long-term users of oral contraceptives. Two studies relate risk with duration of use of the contraceptive, the risk being much greater after four or more years of oral contraceptive use. While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass or shock. A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time. 5. USE IN OR IMMEDIATELY PRECEOING PREGNANCY, BIRTH OEFECTS IN OFFSPRING, ANO MALIGNANCY IN FEMALE OFFSPRING. The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidaf estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated to be on the order of 1 to 4 in 1000 exposures. Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception. Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy. Male children so exposed may develop abnormalities of the urogenital tract. Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes. An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of sex hormones, including oral contraceptives, in pregnancy. One case control study has estimated a 4.7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal withdrawaf tests for pregnancy or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 live births. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives. Embryos with these anomalies are virtually always aborted spontaneously. Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown. Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks. It is also recommended that women who discontinue oral contraceptives with the intent of becoming pregnant use an alternate form of contraception for a period of time before attempting to conceive. Many clinicians recommend three months although no precise information is available on which to base this recommendation. The administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy. 6. GALLBLAOOER OISEASE. Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives and estrogens. In one study, an increased risk appeared after two years of use and doubled after four or five years of use. In one of the other studies, an increased risk was apparent between six and twelve months of use. 7. CARBOHYORATE ANO LIPIO METABOLIC EFFECTS. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives. An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives. 8. ELEVATED BLOOO PRESSURE. An increase in blood pressure has been reported in patients receiving oral contraceptives. In some women hypertension may occur within a few months of beginning oral contraceptive use. In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers. The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year. Age is also strongly correlated with the development of hypertension in oral contraceptive users. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives. Hypertension that develops as a result of taking oral contraceptives usually returns to normal after discontinuing the drug. 9. HEAOACHE. The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause. 10. BLEEOING IRREGULARITIES. Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind. In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy. If pathology has been excluded, time or a change to another formulation may solve the problem. Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since this may increase the risk of thromboembolic disease. Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives. Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods. Postuse anovulation, possibly prolonged, may also occur in women without previous irregularities. 1t. ECTOPIC PREGNANCY. Ectopic as well as intrauterine pregnancy may occur in contraceptive failures. 12. BREAST FEEOING. Oral contraceptives given in the postpartum period may interfere with lactation. There may be a decrease in the quantity and quality of the breast milk. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The effects, if any, on the breast-fed child have not been determined. If feasible, the use of oral contraceptives should be deferred until the infant has been weaned. **PRECAUTIONS: General:** 1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another physical examination being performed. 2. Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size. 3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree. Patients becoming significantly depressed while taking oral contraceptives should stop the medication and use an alternate method of contraception in an attempt to determine whether the symptom is drug-related. 4. Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, asthma, or cardiac or renal insufficiency. 5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy. If jaundice develops in any patient receiving such drugs, the medication should be discontinued. 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients. 7. Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency. 8. Serum folate levels may be depressed by oral contraceptive therapy. Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency. 9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted. 10. Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives: a. Increased sulfobromophthalein retention. b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. c. Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG, free T4 concentration is unaltered. d. Decreased pregnanediol excretion. e. Reduced response to metyrapone test. **INFORMATION FOR THE PATIENT: (See Patient Package Insert). ORUG INTERACTIONS:** Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin. **CARCINOGENESIS, PREGNANCY, NURSING MOTHERS: See CONTRAINOICATIONS and WARNINGS. ADVERSE REACTIONS:** An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see WARNINGS): Thrombophlebitis. Pulmonary embolism. Coronary thrombosis. Cerebral thrombosis. Cerebral hemorrhage. Hypertension. Gallbladder disease. Liver tumors. Congenital anomalies. There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: Mesenteric thrombosis. Neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis. The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug-related: Nausea, usually the most common adverse reaction. Vomiting, occurs in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally. Gastrointestinal symptoms (such as abdominal cramps and bloating). Breakthrough bleeding. Spotting. Change in menstrual flow. Dysmenorrhea. Amenorrhea during and after treatment. Temporary infertility after discontinuance of treatment. Edema. Chloasma or melasma which may persist. Breast changes: tenderness, enlargement, and secretion. Change in weight (increase or decrease). Change in cervical erosion and cervical secretion. Possible diminution in lactation when given immediately postpartum. Cholestatic jaundice. Migraine. Increase in size of uterine leiomyomata. Rash (allergic). Mental depression. Reduced tolerance to carbohydrates. Vaginal candidiasis. Change in corneal curvature (steepening). Intolerance to contact lenses. The following adverse reactions have been reported in users of oral contraceptives, and the association has been neither confirmed nor refuted: Premenstrual-like syndrome. Cataracts. Changes in libido. Chorea. Changes in appetite. Cystitis-like syndrome. Headache. Nervousness. Oizziness. Hirsutism. Loss of scalp hair. Erythema multiforme. Erythema nodosum. Hemorrhagic eruption. Vaginitis. Porphyria. Impaired renal function. (ORTHO-NOVUM 1/50□21 and ORTHO-NOVUM 1/50□28 contain tartrazine. Allergic reactions have been reported with the ingestion of this dye in some patients.) **ACUTE OVERDOSE:** Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females.

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* **INDICATIONS:** Based on a review of this preparation by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: **Possibly effective:** In cutaneous candidiasis; superficial bacterial infections; the following conditions when complicated by candidal and/or bacterial infection: atopic, eczematoid, stasis, nummular, contact, or seborrheic dermatitis, neurodermatitis, and dermatitis venenata; infantile eczema; lichen simplex chronicus; and pruritus ani and pruritus vulvae.

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis; history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely establishe therefore, do not use extensively on pregnant patients, in lor amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsusceptit organisms (including fungi other than candida). Should superinfe tion due to nonsusceptible organisms occur, administer suitol concomitant antimicrobial therapy; if favorable response is not prom discontinue the preparation until adequate control by other or infectives is effected. If extensive areas are treated or if the occlus technique is used, the possibility exists of increased systemic abso tion of the corticosteroid; suitable precautions should be taken. irritation develops, discontinue the product and institute appropric therapy.

ADVERSE REACTIONS: Sensitivity reactions to topical use of gramici are rare. Hypersensitivity to nystatin is extremely uncommon. Hyp sensitivity to neomycin has been reported and articles in the curr medical literature indicate an increase in its prevalence.

The following local adverse reactions have been reported w topical corticosteroids either with or without occlusive dressings: bu ing sensations, itching, irritation, dryness, folliculitis, secondary inf tion, skin atrophy, striae, miliaria, hypertrichosis, acneform eruptio maceration of the skin, and hypopigmentation. Contact sensitivity t particular dressing material or adhesive may occur occasionally. C toxicity and nephrotoxicity have been reported.

For full prescribing information, consult package insert.

HOW SUPPLIED: Available in 15, 30, and 60 g. tubes. It is also ov able in jars of 120 g. (4 oz.) for hospital or institutional use only.

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Aspiration and Obstetrical Anesthesia

John C. Kruse, M.D. and Charles P. Gibbs, M.D.

Abstract: Aspiration of gastric contents remains a problem during labor and delivery. In 1975-76, there was one death in the 39 reported to the Maternal Mortality Committee attributable to this cause. The parturient has multiple reasons to be at high risk for this problem, and the indications for general anesthesia should be carefully evaluated. If indicated, prophylactic measures can be taken to minimize the incidence of this devastating complication.

A two-year (1975-76) review of 39 maternal deaths in Florida revealed one death attributable to aspiration of gastric contents during anesthesia (Maternal Mortality Committee records of Florida). Moreover, the authors are personally aware of several other instances of nonfatal aspiration. Although the latter cases did not claim lives, they were costly in terms of not only expense but also morbidity as evidenced by a recent study by Arms et al.[1] in which the average hospital stay for patients who had aspirated gastric contents was 21 days. Mortality figures for aspiration range from 3% to 82%.[1-4] Since the cause of this morbidity and mortality is almost always preventable, and because it is almost always associated with general anesthesia, the Committee on Maternal Mortality feels that a review of the management of general anesthesia and aspiration in obstetrics is indicated.

The pregnant patient is particularly susceptible to aspiration. The most important reason is that the onset of labor is almost entirely unpredictable and she may therefore have eaten shortly before the onset of labor. Other reasons that she is quite likely to have a full stomach are a delayed gastric emptying time[5] and an increased gastrin secretion.[6] Furthermore, O'Mullane[7] has shown that the presence of a gravid uterus and the lithotomy position greatly increase gastric tone, thereby increasing the likelihood of vomiting or regurgitation during anesthesia. The use of fundal pressure to help the mother expel the baby can also encourage the aspiration of gastric contents by increasing intra-abdominal pressure. Also, because she may not have been adequately instructed, the patient may have eaten a large meal while in labor before entering the hospital. That these observations are clinically relevant is evident from the work of Roberts and Shirley,[8] who found that 24% of the patients in labor and 29% of those who had been fasted overnight in preparation for elective cesarean section had at least 25 ml of gastric contents in their stomach. Obviously, fasting does not insure an empty stomach.

These conditions illustrate why the pregnant patient is more susceptible to the hazard of vomiting, regurgitation, and aspiration. Moreover, it should be apparent that the risk of general anesthesia for the pregnant patient is sufficient to question its use except when medically indicated, as in the following circumstances. Some cesarean sections will require general anesthesia; nearly all vaginal deliveries, however, can be accomplished without general anesthesia. Local infiltration, pudenal block, pudenal block plus inhalational analgesia, or major regional block (such as epidural, caudal, or spinal) will suffice in nearly all instances. Recognizing that current obstetrical practice encourages cesarean sections for many of the following indications, those vaginal deliveries that may require general anesthesia would include a difficult breech delivery, shoulder dystocia, difficult forceps application in the face of fetal distress, and version and extraction of a second twin or transverse lie. Actually, management of the first three instances could be accomplished quite well under major regional anesthesia if the block were in effect when the problem occurs. The need for general

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This presentation has been reviewed and approved by the Maternal Mortality Review Committee of the Florida Department of Health and Rehabilitative Services, Samuel L. Renfroe, Ocala, Chairman.

anesthesia in these instances results more from a consideration of time than from any superiority of technique.

When general anesthesia for obstetrical procedures is indicated, the risk of aspiration can be lessened by taking certain precautions, the most important probably being the use of endotracheal intubation with a cuffed endotracheal tube. The presence of the cuffed tube in the trachea while the patient's protective reflexes are obtunded will effectively prevent most gastric contents from entering the lungs. The incidence of vomiting, regurgitation, and aspiration during general anesthesia via mask or uncuffed endotracheal tube has been reported as approximately 1:6,000 vaginal deliveries, 1:430 cesarean sections,[9] and 1:666 vaginal deliveries and cesarean sections.[2] Moreover, in another study in which dye was placed in the patient's stomach before mask or cuffless endotracheal anesthesia, 24 of 300 patients vomited and aspirated. In another 25 patients the aspiration was "silent," i.e., dye was found beneath the vocal cords but no vomiting had occurred.[10]

Another prophylactic measure that has recently received wide publicity and usage is the administration of 15-30 ml of oral antacid to decrease the acidity of gastric contents[8,11,12] and, therefore, perhaps the severity of lung damage.[13] On the surface, this practice seems logical, and it may be. However, completed studies at the University of Florida indicate that the use of antacid may cause as much damage as does acid aspiration.[14] Until these new data have been held up to critical review, the prophylactic administration of antacid to obstetrical



We are most grateful to Mr. Dennis Hoy, an architecture student at the University of Florida, for his sketch to illustrate this article.

patients remains of questionable value.

Yet another prophylactic measure, the preoperative administration of glycopyrrolate, looks promising but is not fool proof. Glycopyrrolate, a relatively new anticholinergic drug, has several advantages over atropine or scopolamine. It does not cross the blood-brain barrier and will not, therefore, cause the central cholinergic symptoms of disorientation often seen with scopolamine and atropine. In addition, given intramuscularly 30 minutes before the introduction of anesthesia in a dose of 0.4 mg, the gastric pH was raised above the critical level of 2.5 in 66% of a group of parturients studied by Baraka et al.[15]

A commonly used technique for general anesthesia, when indicated, is as follows. The patient is placed in a head-up position and is given 0.2-0.3 mg of glycopyrrolate iv followed by preoxygenation and 3-4 mg of d-tubocurare or a comparable dose of another depolarizing muscle relaxant. She is then given 3-4 mg/kg of thiopental[16] or 1 mg/kg of ketamine iv[17] followed immediately by 1.5-2.0 mg/kg of succinylcholine iv. Cricoid pressure[18] is applied by an assistant, endotracheal intubation is accomplished as quickly as possible, and the cuff is immediately inflated. After making sure the tube is in place, 30% to 70% nitrous oxide is added[19] and the operation proceeds. After the baby is delivered, 0.5% halothane, or any narcotic, can be added to supplement the analgesia of nitrous oxide. Halothane in this concentration does not promote uterine atony.[20] After the operation the patient should be awake and conscious before the endotracheal tube is removed. Thus, her protective reflexes are intact, and aspiration is unlikely should vomiting occur on emergence. This technique is widely used and compares favorably with regional techniques.[21] This method was used for 549 cesarean sections at the University of Florida during the same two years of the Maternal Mortality Committee's review without one instance of aspiration occurring.

In spite of all precautions, aspiration will still occasionally occur. Should this happen, and should the aspirate be liquid or particulate (as opposed to large chunks), the patient may exhibit wheezes, coughing, tachycardia, cyanosis, and pulmonary edema. However, these signs and symptoms, as well as x-ray findings, may lag several hours behind the actual pathophysiologic conditions. Probably the most important and most reliable early sign is a falling arterial oxygen tension.[22] If aspiration occurs, the first step is to clear the airway. If large chunks block the airway, bronchoscopy is necessary for removal. After clearing the airway, the next and most effective form of treatment is the application of positive-pressure ventilation with positive and end-expiratory pressure.[22] In some instances, spontaneous ventilation with positive end-expiratory pressure is sufficient. The use of steroids and antibiotics, although not harmful, has not been proven effective or necessary.[22,23] Of course, prevention is ultimately the best form of treatment, which includes patient education and the proper choice of anesthetic techniques, i.e., those designed to fit the obstetrical demand.

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A Word of Warning

Marked Increase in Hydromorphone (Dilaudid) Addiction

Dale K. Lindberg, M.D.

Abstract: More than half of the addicts presenting themselves to a large methadone maintenance program are currently addicted to Hydromorphone (Dilaudid). The quality of the heroin currently available is so poor that the addict is turning to a more reliable and consistent quality opiate drug to maintain his addiction even at a current street price of around $20 for a 4 mg tablet.

The author presents many of the methods used by the addict to obtain these narcotics from physicians and others. Some suggestions are made to be used by physicians in dealing with this severe problem.

The number of persons addicted to the narcotic-analgesic Dilaudid (hydromorphone) has increased at a startling rate. More than half of the patients applying for treatment in a large methadone maintenance and detoxification program in southeast Florida report it as their primary drug. The average daily use is about 15 of the 4 mg tablets. Several tablets are "cooked" with water and injected intravenously. This is repeated as needed, at least several times a day, the frequency and amount varying with availability of the drug. The average patient reports withdrawal symptoms with less usage than 10 tablets or 40 mg per day.

Serving as medical director of the program and closely involved in the diagnosis and treatment of patients for the past eight years has enabled me to establish rapport with many of them. After assuring the addict that I do not want names or other identifying information, I have found there to be several sources for Dilaudid. The first and most common is the "dealer" who may also sell heroin. His final price is $15 to $20 per tablet with a few reporting up to $25. He obtains his supply in large lots from a few unethical pharmacists but commonly from some long-term disabled patients who claim pain in excess of reality as well as from the "doctor shoppers."

Another source is the addict who "hits" or "makes" a physician with the story of tic doloreaux, dental abscess, or renal colic. He always has an excellent history right out of a textbook and a very convincing plea for this frequently recurring illness. He claims hospitalization several times and always with small stones that "pass after a while." He has been told that he does not need further hospitalization, just something for the pain. Doctors have tried many pills, Talwin, codeine, morphine, Demerol, but they don't work. "The last two times one that did a good job starts with a D — dil something," and if the doctor cannot remember he gets a little prompting — one orally every three or four hours and the pain usually goes away in three or four days. If the addict succeeds in getting 24 tablets, he may try for some for his next attack — maybe in a week — but definitely in the next three or four weeks. He will be sure to see this physician again in a month or so. Fresh injection "tracks" or old black or scarred veins on his arms or hands may betray him.

Others pay "doctor shoppers," older people, who have severe angina or other obviously painful affliction to go to many physicians on a regular basis with the same complaints and treatment with medicine "and one or two Dilaudids — the yellow ones — a day for when the pain gets bad." Some patients with grotesque skin cancers make the rounds with severe pain, hard to deny, but which may be false.

Some "doctor shoppers" see a physician or two each day and return at regular monthly intervals. They may sell the tablets wholesale at $8 to $10 each by the 100. One has known "partnerships" with young sellers and lives in luxury. Then there are the forgers who see a physician and get a prescription from him for some innocuous drug. He may steal a loose pad or have a friendly printer prepare some for him. The more experienced write for 24 Dilaudid tablets on one Rx and another for 100 tablets of an expensive muscle relaxant to allay the fears of the ethical pharmacist. The drug store robberies and burglaries are other sources.

The most heinous sources, however, are physicians who may prescribe to pay off blackmail or gambling debts but some write on a "fee for service" basis. They charge the patient $1 to $3 cash for each tablet they write for; another equally criminal person is the pharmacist who sells each tablet for $8 to $12 to known addicts.

Other narcotic-analgesics are known to be quite satisfactory. In my experience with over 2,000 addicts, several have had a primary addiction to Demerol (meperidine), an uncommon few to morphine, and none to the other injectable narcotics.

The practicing physician should be very cautious in prescribing hydromorphone and try to markedly reduce his use of it.

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Computerized Tomography Body Scanning In A Community Hospital

Hugh P. Smith Jr., M.D.; Robert J. Meli, M.D.; William E. Copenhaver, M.D., and John S. Stewart, M.D.

Abstract: A computerized tomography body scanner has proved beneficial among patients in a 250-bed community hospital. Significant assistance has been derived from diagnostic evaluation of liver masses and bile duct caliber, renal masses and cysts; in pancreatic studies, pulmonary and pleural lesions and in complex diagnostic problems.

The newer x-ray computed tomographic machines are proving to be valuable adjuncts in diagnostic evaluation and in localization of pathologic processes throughout the body. The 20-second scanner helps clarify obscure problems and because of the ease of the examination sick patients may be studied rapidly and appropriate therapy instituted.

The CT study should be tailored to the individual patient in order to obtain optimal views and maximal information. When the patient holds his breath there is definite improvement in the picture, and thus the newer, faster scanners offer significantly better pictures than the older units. Intravenous iodinated contrast material is useful in most renal and hepatic studies, and oral contrast material helps in pancreatic studies.

Following are some significant conditions encountered in approximately 500 CT Body examinations.

Hepatobiliary Disease

CT is an excellent method for showing dilated intrahepatic bile ducts and at times dilated extrahepatic ducts may be identified. The gallbladder is usually well seen and gallstones are commonly recognized. Pancreatic calcifications and pseudocysts can be recognized and tumors may be identified if they are large enough. Pancreatic carcinomas do not have a detectable CT difference from normal pancreatic tissue and are unrecognizable when too small to distort the outline of the pancreas. Primary hepatic tumors and hepatic metastases can often be detected, and we find intravenous contrast medium may aid in revealing metastases. In one patient a liver abcess was diagnosed and aspirated with a percutaneous needle all under CT guidance (Figs. 1A, 1B).



Fig. 1A. — Dilated extrahepatic ducts.

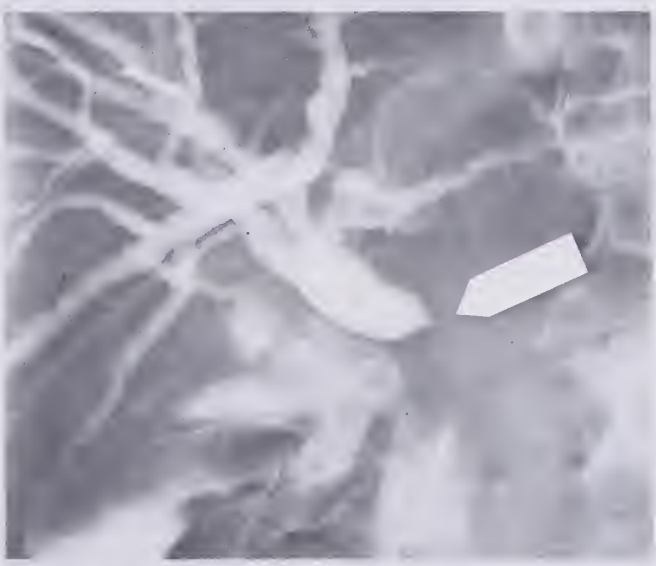


Fig. 1B. — Percutaneous cholangiogram shows carcinoma obstructing extrahepatic bile duct.

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Urinary Tract

Kidneys are shown very well even without contrast, therefore in patients when nonvisualization occurs on routine radiography, CT may help greatly. Often the kidney is shown even if in a shrunken, tumorous or hydronephrotic state. Renal cysts are detectable especially after intravenous contrast enhancement. Commonly we find several more cysts than anticipated after a drip infusion pyelogram with laminograms, and sometimes more than revealed on selective renal arteriography. Tumors often can be separated from cysts on the CT scan, although one cannot make the diagnosis in all cases, for hemorrhagic cysts may have an elevated CT number mimicking a solid mass lesion.

Ordinary calculi are well seen. One uric acid stone was well seen on CT but invisible on plain x-rays. Unfortunately a suspected uric acid calculus in another patient failed to visualize on CT so we do not know with what frequency these stones will show (Figs. 2,3).

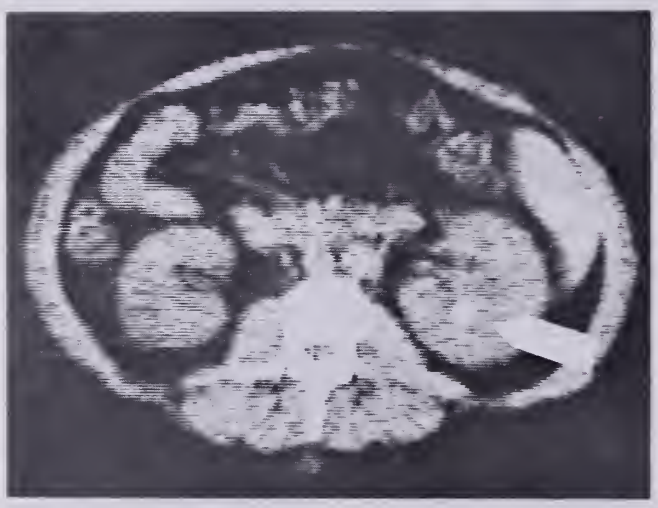


Fig. 2. — Nonopaque stone.

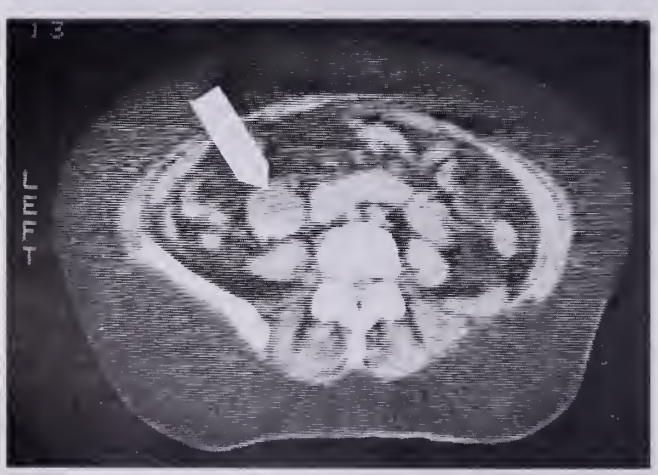


Fig. 3. — Kidney which did not show on intravenous pyelography.



Fig. 4. — Rectus hematoma.

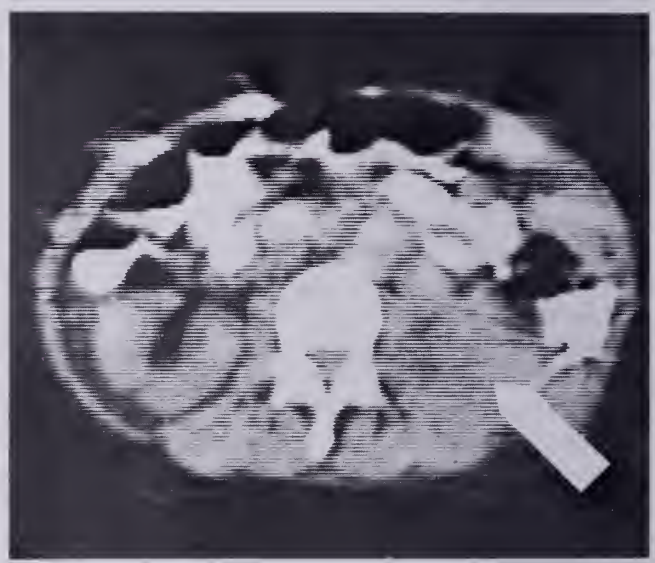


Fig. 5. — An abcess from a ruptured retrocecal appendix.

Mass Localization and Identification

CT appears to be the best available technique for studying the retroperitoneal area especially in localizing retroperitoneal tumors. It helps delineate the extent of masses and metastases in lymph nodes, liver and lungs. We found it useful in an interesting anterior abdominal wall mass which appeared after strenuous exercise and was finally diagnosed as a rectus muscle hematoma (Figs. 4,5).



Fig. 6. — Carcinoma of lung poorly shown on conventional x-rays.



Fig. 7. — Pulmonary infarction poorly seen on conventional x-rays.

Thoracic Area

CT scanning adds another dimension in studying the intrathoracic regions. Pleural fluid, peripheral metastases and other pulmonary masses and infiltrates show up rather well. It helps clarify extension of tumors. It is excellent for showing areas poorly seen on routine radiographs in very ill patients, i.e., behind the heart or below the dome of the diaphragm (Figs. 6,7).

Osseous Structures

We have found CT useful in evaluating a complex fracture of a vertebral body, in several cases of lumbar spinal stenosis, in a few unusual osseous metastases, and in a fatty tumor near the hip. The procedure is useful in selected fractures, tumors and metastases especially in relation to the vertebra and pelvic osseous structures.

Gastrointestinal Tract

CT seldom helps as well as conventional radiographic techniques in evaluating the gastrointestinal tract. We have found it useful to give dilute iodinated contrast material orally to help separate the gastrointestinal tract from other intra-abdominal structures.

Summary

These reports give a few examples showing the diagnostic ability and clinical usefulness of the CT body scanner in a community hospital of approximately 250 beds. It is often a deciding factor in planning the patient's therapy.

● Dr. Smith, Department of Radiology, Naples Community Hospital, Naples 33940.

Los Angeles County Medical Association lends perspective to a decade of rising costs with 1967 to 1977 comparisons . . . **Hospital** charges up 194 percent . . . **Physician** fees up 214 percent . . . **Legal** fees up 220 percent . . . **Postal** fees up 226 percent . . . **Social Security** taxes up 308 percent . . . **HEW** budget up 364 percent . . . **Federal** budget up 400 percent and cost of running **Congress** ahead of all with 422 percent increase!

Effective Blood Pressure Reduction With Metolazone

Edward W. St. Mary, M.D.

Abstract: Twenty-seven hypertensive patients were treated with metolazone either alone or concomitantly with other antihypertensive agents, chiefly clonidine, for periods up to 15 months. The majority of patients had suffered from hypertension of several years duration and had been previously treated with various other antihypertensive drugs. The mean duration of metolazone therapy during this period was 15 weeks. In all but one case, the dose of metolazone was 5 mg given once daily.

During metolazone therapy, blood pressure declined in 24 of 27 patients from a mean of 181/104 mm Hg initially to 141/88 mm Hg when this review was undertaken. Seven patients experienced generally mild side effects during treatment including five who received several other antihypertensive drugs concurrently.

Metolazone* is a new sulfonamide diuretic-antihypertensive chemically and pharmacologically related to the thiazides. This potent long-acting agent has been shown in a number of recent clinical reports[1-3] to be highly effective and generally well tolerated in the treatment of mild to moderate hypertension.

Investigators who conducted formal comparative trials have reported that metolazone compared favorably in antihypertensive efficacy with chlorthalidone[4] and hydrochlorothiazide.[5] In a recent crossover study in 33 patients, Sambhi et al[6] obtained a significantly more effective antihypertensive effect with metolazone given in a single daily dose of 5 mg than with hydrochlorothiazide given in two 50 mg daily doses. The study of long-term administration of metolazone carried out by Cangiano et al[7] did not reveal any problems with developing tolerance to the drug or an increase in side effects after up to 92 weeks of treatment. Metolazone has also been used effectively together with other antihypertensives such as methyldopa, reserpine, and hydralazine.[7,8]

The suggestion of a low incidence of side effects in a medication effective in single daily doses led us to introduce metolazone into our practice for treatment of patients with essential hypertension.

After using the drug for over a year and gaining the impression that it was performing well, we decided to attempt to characterize the effects of the drug in a more specific manner by reviewing the records of those patients who had received the drug during this period. While we recognize the difficulties of reporting this type of data, where active controls are absent, it seems definitely worthwhile for physicians to undertake such projects from time to time as this is virtually the only way in which other practitioners can assess the results of a drug's profile in actual clinical settings. Thus this paper reports on initial results with metolazone.

Patients and Methods

A retrospective random review of our patient records was conducted to identify patients for whom we had prescribed metolazone for varying degrees of essential hypertension. Thirty-two charts were pulled. Of this number, five could not be included in analysis of blood pressure response either because they had no follow-up visit or pressure was stabilized at the time metolazone therapy was initiated.

The resultant group consisted of 11 male and 16 female office patients, almost all Caucasian, with mild to moderate essential hypertension. The diagnosis of essential hypertension was made by history in the absence of any discernible pathology indicative of a specific etiology. Almost all these patients had hypertension of several years' duration when metolazone was either added to existing regimens or substituted for an antihypertensive agent then being given. Eight hypertensive patients had been receiving metolazone alone when this review was conducted. The mean duration of metolazone treatment was 15.4 weeks, with therapy ranging from two weeks to 15 months as of this report.

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The patients were 30 to 72 years old, with a mean of 52.3 years. Their most commonly associated medical problem was coronary artery disease; angina and tachycardia were common complaints, and three patients had a history of myocardial infarction.

Before therapy with metolazone, systolic sitting pressures in these patients ranged from 144 to 220 mm Hg, with a mean of 181 mm Hg. Initial diastolic pressures ranged from 82 to 130 mm Hg, with a mean of 104 mm Hg. All patients selected for this review had either systolic pressure > 140 mm Hg or diastolic > 95 mm Hg. Only one patient had an initial systolic pressure < 150 mm Hg and only one had a diastolic reading < 90 mm Hg. Eight patients had diastolic pressure < 100 mm Hg so that the majority had a moderate degree of hypertension with diastolic pressure between 100 and 120 mm Hg.

Of the 19 patients receiving combination therapy, 15 were treated with metolazone and clonidine concurrently including four patients for whom propranolol or hydralazine was also used. The usual dose of metolazone was 5 mg once daily, but one patient was started with 2.5 mg per day and then increased to 10 mg per day after two weeks. Clonidine was given in a dosage of 0.1 mg once or twice daily.

Because this was our first systematic use of metolazone, special attention was given to patient complaints that might be drug related.

Results

Substantial reductions in blood pressure occurred during metolazone therapy as seen in the individual patient responses shown in Table 1. Mean systolic pressure was reduced from 181 to 141 mm Hg, a decrease of 22%. Mean diastolic pressure was reduced from 104 to 88 mm Hg, a decrease of 15%. Improvement in blood pressure in the eight patients treated with metolazone alone was similarly impressive. In the latter patients, mean systolic pressure was reduced from 188

Patient Number	Sex	Age (Years)	Duration of Therapy (Weeks)	Blood Pressure (mm Hg)		
				Initial	Final	Change
Metolazone Alone (n=8)						
07	F	49	5	180/120	140/82	-40/38
09	M	63	2	150/82	150/80	0/-2
11	F	33	2	160/100	130/78	-30/22
13	M	47	12	210/120	130/100	-80/20
19	F	55	11	190/100	190/110	0/+10
21	M	—	9	220/120	158/100	-62/20
24	F	72	12	200/98	170/80	-30/18
29	F	45	2	194/130	162/110	-32/20
MEAN		52.0	6.9	188/109	154/93	-34/16
Metolazone as Concomitant Medication (n=19)						
01	F	56	5	182/110	138/80	-44/30
03	F	53	32	170/90	140/82	-30/8
04	F	54	19	220/110	120/76	-100/34
05	M	38	12	190/110	145/110	-45/0
06	F	69	2	178/100	122/70	-56/30
08	F	60	9	220/90	168/80	-52/10
10	M	30	12	190/120	150/110	-40/10
12	M	59	20	170/92	120/84	-50/8
14	F	45	28	182/112	180/80	-2/32
15	F	58	5	150/100	130/90	-20/10
16	M	67	60	192/100	180/90	-12/10
17	M	33	9	144/90	140/90	-4/0
18	M	64	12	190/102	140/72	-50/30
25	F	57	5	165/95	150/95	-15/0
26	M	49	9	150/90	116/80	-34/10
27	F	35	20	190/108	160/90	-30/18
30	F	54	8	150/110	126/80	-24/30
31	F	63	10	178/100	156/90	-22/10
32	M	51	52	170/110	140/100	-30/10
MEAN		52.4	17.3	178/102	143/87	-35/15

Table 1. — Patient Response to Metolazone Therapy.

Table 2. — Systolic Blood Pressure Before and After Therapy with Metolazone.

	(Number of Patients)				
	<150	150-169	170-189	>189	(mm Hg)
Before therapy	1	6	8	12	
Final reading	15	8	3	1	

Table 3. — Diastolic Blood Pressure Before and After Therapy with Metolazone.

	(Number of Patients)				
	<90	90-99	100-109	>109	(mm Hg)
Before therapy	1	7	8	11	
Final reading	14	6	3	4	

to 154 mm Hg (an 18% decrease), while mean diastolic pressure was reduced from 109 to 93 mm Hg (a 15% decrease).

After metolazone use, 15 of the 27 patients had systolic pressure < 150 mm Hg, while 14 had diastolic pressure < 90 mm Hg and 20 had diastolic pressure < 100 mm Hg (Tables 2 and 3). Only three patients failed to show improvement during metolazone treatment. One was a 33-year-old male treated with metolazone and clonidine whose initial blood pressure was borderline, 144/90 mm Hg. After two months of therapy, his blood pressure was 140/90 mm Hg. This patient probably should have been omitted from the review, but he just met our criteria for elevated systolic pressure. Another patient who failed to respond to treatment was a 63-year-old male whose blood pressure also was reasonably well controlled at 150/82 mm Hg on hydrochlorothiazide before he was switched to metolazone. Hydrochlorothiazide had been discontinued because of complaints of heartburn. The patient was dropped from metolazone therapy after two weeks because of complaints of an upset stomach; his pressure at that time was 150/80 mm Hg. In addition, he claimed to have fainted during the course of treatment. The third patient, a 55-year-old woman with anxiety neurosis, was treated with metolazone alone for 11 weeks. Her blood pressure increased from 190/100 to 190/110 mm Hg during this time.

Side effects were encountered in six patients, but in only one of these was therapy discontinued, a 69-year-old woman with arthritis who complained of dry mouth and leg cramps after metolazone and clonidine were administered. She was dropped from treatment after two weeks of therapy during which her blood pressure had been reduced from 178/100 to 122/70 mm Hg. A 67-year-old man experienced some "shakiness" after clonidine 0.1 mg twice daily was added to his daily regimen of metolazone 5 mg. A 54-year-old woman complained of heart pounding while receiving propranolol (30 mg per day) as well as clonidine and metolazone. Clonidine was discontinued after one week without further difficulty. Another patient, a 49-year-old woman with a history of alcoholism and nervous tension, complained of poor appetite, gas pains, and weak pulse while taking metolazone. Tingling feeling in one patient and tiredness in another were attributed to clonidine and methyldopa, respectively.

Metolazone, either alone or in combination with other antihypertensives, appeared to be very well tolerated in all of the other patients. There were no signs of clinical hypokalemia. Potassium supplements were prescribed in the few cases in which laboratory hypokalemia (< 3.5 mEq) was revealed during the course of routine workups.

Discussion

We have found metolazone to be an effective and well tolerated antihypertensive agent. Its chief advantage in this series was its 24-hour diuretic action, which is effective in counteracting the initial volume expansion that is an underlying factor in the majority of hypertensives. The prolonged action of this agent also minimized the compliance problem that often complicates the effective control of hypertension. The antihypertensive effects of metolazone persisted even when patients missed several consecutive doses. In addition, nocturia failed to be a problem since metolazone could be given once daily in the morning.

Metolazone was well tolerated in these patients. Of the five who did report side effects, three had received concomitant therapy and thus their adverse side effects could not be attributed to metolazone alone. Only two of 23 patients were discontinued from treatment because of side effects. In our practice, metolazone has largely replaced methyldopa or the combination of methyldopa and hydrochlorothiazide, thus eliminating the frequent complaints of sedation associated with the use of the latter agents. Metolazone worked well in combination with clonidine or propranolol, apparently augmenting blood pressure response without an increase in the incidence of side effects. The concomitant use of metolazone and clonidine, with or without the addition of propranolol, did not appear to increase side effects.

Metolazone was successfully used for both initial treatment of hypertension and in place of other agents that had failed to provide adequate control.

The blood pressure of a 49-year-old woman with a history of myocardial infarction and edema failed to respond to treatment with furosemide 40 mg/day over a

seven month period (initial pressure 160/110 mm Hg, final pressure 180/120 mm Hg). Following discontinuation of furosemide and after one month of treatment with metolazone 5 mg daily, her blood pressure was reduced to 133/84 mm Hg and was well controlled one month later at 140/82 mm Hg.

The excellent results obtained in our series of patients demonstrate that metolazone appears to be an effective antihypertensive agent with a favorable therapeutic profile. Its use was associated with effective control of blood pressure with minimal side effects. Obviously, we are still a long way from the ideal solution to blood pressure control, but treatment with metolazone alone or combined with nondiuretic antihypertensives represents a useful addition to the physician's therapeutic options for the attainment and maintenance of lowered blood pressure.

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SPECIAL ARTICLES

Relationship of Private Medical Practice and Public Health

Some Early Morning Thoughts

Robert D. May, M.D., M.P.H.

Abstract: The vital importance of a continuing close relationship between the private medical sector and the public health sector is explored. Since both public health and private medicine are in some flux, the importance of a meaningful togetherness is suggested.

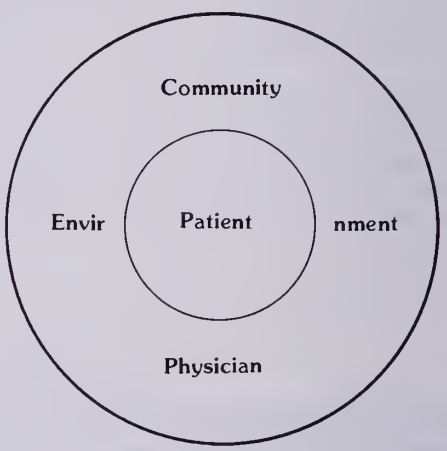
Physicians are remarkable individuals. Qualities of character found among them sometime appear lacking in other community leaders. A uniqueness of purpose, wholeness of intellect, and commonness of concern bind them to the community.

The core of concern which unifies and strengthens physicians may be the early, intimate knowledge of the importance of a meaningful relationship such as that between the first sputtering cry of the wanted infant and the new, excited mother and proud father. It may be an intimate sharing — with parents in the growth and development of this new person — and a continuing concern with the relationship of this new person — to parents, grandparents, siblings, day care center, school and adolescent groups.

Perhaps physicians because of their innate working knowledge of the vital effect of relationships on the lives of their patients become more meaningful persons in their own lives and thus more concerned with the environment of themselves, their patients and their community.

Entitle it holistic or comprehensive or as some would have it good, old-fashioned medical care. This helps to understand the close relationship of private medical practice and public health which is an organized community effort to protect, maintain and improve the quality of life.

For the beginning of public health some scholars go back to the Hebrew tribes pointing out the proscription against pork and prescription for circumcision. Actually



one of the first recorded public health efforts involved a physician, Edward Jenner. This village truant from school in the 1750's must be considered a public health pioneer. He noted the absence of smallpox in milkmaids exposed to cowpox, tried vaccination, and vigorously recommended it as a means to control a disease which was the major cause of blindness in England and fatal to 30% of all children prior to age three.

Another notable public health event occurred about 50 years later. In 1848 during a cholera epidemic in England a public servant in the community noted the relationship of new cases and use of the Broad Street pump. Armed with this observation, John Snow ordered the pump handle removed which effectively brought the epidemic under control in that part of London.

The relationship of epidemic diseases and the observations and interventions of these physicians played a major role in the health of the community, country and eventually the world.

The history of many Florida counties documents the important relationship between the private practice of medicine and the continuing battle to solve community health problems.

My grandfather, Dr. Robert E. Lee May, a private practitioner in Jacksonville in the late 1890's and early

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Presented for the Pensacola Educational Program, Pediatric Grand Rounds, Children's Medical Center, Sacred Heart Hospital, Pensacola.

1900's, became convinced as to the efficacy of smallpox vaccine. His public health approach was to go out in the back yard once a week, round up all his childrens' playmates, bring them into the kitchen and vaccinate those not yet inoculated. Such was the relationship of public health practice and a Duval County physician.

In the early 1800's the population of Pensacola was some 4,000 persons. By late 1825 epidemics of yellow fever had reduced this number to 1,400. Commerce and industry were virtually destroyed. Small wonder that one of the first ordinances of territorial rule under Andrew Jackson in 1821 established a Board of Health and Quarantine. This ordinance also regulated the practice of medicine.

In 1826 malaria frequently appeared in Escambia County. Public health physicians such as Surgeon Isaac Hules, Commandant of the Naval Hospital, and Robert B. S. Hargis, Port Physician, as well as private practitioners such as Drs. J. C. Whiting, John and George Brosnaham and J. S. Herron Jr. fought for improvement of the health of the people.

The important collaborative relationship is not really unusual between physicians in private practice and in pubiic health. Indeed all physicians are interested in maintaining wellness and preventing illnesses among their patients and in their community. Those in private practice spend much time in routine patient wellness and health maintenance checkups. They are the educators of the community in a unique manner. They accept the calls to do the PTA circuit and talk about everything from community history to the sexual activity of the iguana. This is an important aspect of medical practice; however, they may tire of reassuring PTA mothers that just because two-year-old Billy plays with his penis he won't necessarily grow up to be a sex maniac.

What should a private practitioner know about a county health department to be able to educate the community concerning public health?

Organization and Programs

A county health department as an agency of government is organized in a fairly traditional manner. There are usually three major divisions and several special programs. Major divisions provide administrative services, environmental health services, and personal health services. Administrative services can be subdivided into three general categories: fiscal management, personnel management, and vital statistics collection. It is most important that vital statistical material be appropriately analyzed and disseminated on a regular basis. This is especially helpful to practicing physicians individually and through reports to the county medical society. Environmental health services are usually subdivided into three broad categories: air pollution prevention, monitoring and protection; food, water and milk pollution prevention, monitoring and protection, and soil pollution prevention, monitoring and protection. Special areas such as motel, hotel, and swimming pool inspections are of small importance when compared to the first three.

Unfortunately in Florida environmental health activities often have been diverted into separate bureaus and departments. Sometimes this has been done for increased efficiency and sometimes for political reasons.

Personal health services are subdivided into traditional public health programs such as tuberculosis control, venereal disease control, maternal and infant care and immunizations, visiting nurse services, school health, nutrition and special programs which may include family planning, cardiovascular screening and home health services.

Special programs are becoming more a part of public health. It is vital to have the continuous and vigorous involvement of the private practicing physician at the grass roots level in order to plan and implement new special programs effectively. As more special programs are developed such as Medicaid screening, extended family planning, home health services and multiphasic screening, the urgency of private physician participatory involvement becomes more pressing. Most of these new programs have been designed with and can only be carried out by close collaboration and cooperation with the private medical sector.

Planning for the future of public health can be done effectively only with the vigorous understanding and support of private practicing physicians. How do you, as a community leader, see our public health problems in Florida? Is the high VD rate the "community cholera" of today? Is the extremely high incidence of teenage pregnancies our "community smallpox?" Or are these problems acceptable "punishment" for those in the community who are sexually active?

Adolescents, aged 13 to 20, comprise about 12% of the total population in Florida. Well-documented studies show this age group as having many unmet health needs. Are these the "yellow fever" of today?

Your input as a private practicing physician, whether as a generalist or specialist, is vitally important to continuing a meaningful public health effort in Florida. You as a community leader and physician must help educate your community and with public health physicians work to solve the public health problems today and in future years.

What are your early morning thoughts on the relationship of private medical practice and public health?

● Dr. May, Pasco County Health Department, 610 Forest Avenue, New Port Richey, Florida 33552.

Workmen's Compensation Up-Date 1978

James F. Richards Jr., M.D.

Members of the Florida Medical Association will recall that the Association filed petitions in 1975 requesting corrections in the Workmen's Compensation Medical and Surgical Fee Schedule. Evidence was presented in those public hearings in Tallahassee based upon more than 16 million individual charges from the 1974 Medicare records for the state of Florida and additional evidence based upon the Sarasota Survey preparatory to writing the 1975 Florida RVS. Before the hearings were over, we also had information on the statewide survey. After three hearings, we were granted a 32% across the board increase. This brought certain groups into reasonable line with Usual and Customary Fees but it did not adequately correct the surgery and anesthesiology sections, nor did it recognize in the nonsurgical or medical section that there are, in fact, many levels of First Office and First Hospital Visit.

In the past three years, the Chairman of the Council on Medical Economics has also served on the Statutory Advisory Council to Workmen's Compensation, and, through that platform, has been able to represent the Florida Medical Association. Many problems and questions have been considered by that Council other than Medical and Surgical Fee Schedule. The Council is currently involved, for instance, in making suggestions to the legislature for sweeping revisions in the Workmen's Compensation Law to attempt to make the act more self-executing, requiring less litigation. The goal is to make dollars spent in the system go to those who are actually injured and who have decreased capacity to earn income.

Some of the items for which we argued in 1974 and 1975 have been pursued in the Statutory Advisory Council meetings. The Council has advocated several levels of compensation for Office and Hospital Visits. The Chairman of the Council on Medical Economics has, with the help of Blue Shield, converted the Workmen's Compensation Fee Schedule, a four digit code, to the appropriate five digit code as it appears in the 1975 Florida RVS. This was done at the request of the Bureau of Workmen's Compensation. The Bureau has announced that it will begin to recognize, at this time, both the four and five digit code and will ultimately convert to the five digit code. This will, in effect, permit all the agencies within the state to use the same language, descriptors and codes.

The Bureau of Workmen's Compensation, Department of Labor, has printed a new five digit code manual which should be available and physicians interested in receiving manuals should write to the Bureau of Workmen's Compensation, 1321 Executive Center Drive East, Tallahassee, Florida 32301.

The Bureau has also advised that the Initial and Final Medical Reports will be revised so that the column to the far right marked "Do Not Use This Column" will be "Usual and Customary Rate." This is column six. Physicians may begin immediately submitting their fees using the five digit code and reporting the Usual and Customary Charges for services in the column marked "Do Not Use." The Fee Schedule fee will also continue to be entered into the form in the appropriate column, and payments will be based on that schedule. As supplies of the old form are depleted, physicians should request the new forms that will have the column "Usual and Customary Rate."

The Bureau has indicated its intention to accumulate such Usual and Customary data from around the state for the purpose of providing a statistical base from which future revisions of the Fee Schedule may be determined. Should the Bureau follow through on this promise, then the Florida Medical Association may never again have to go through the extremely expensive and time consuming process of filing a petition and attending public hearings as we did for almost a year in 1975.

On behalf of the FMA members who have participated in these efforts, we would like to thank the doctors of Florida for their patience. These deliberations move slowly and cause us to be impatient. We see injustice or inequity and it is frustrating not to be able to correct it immediately. We do see progress and we are happy to be able to report that progress.

Dr. Richards is Chairman of the Council on Medical Economics of the Florida Medical Association and a member of the Statutory Advisory Council to Workmen's Compensation.

● Dr. Richards, 1315 South Orange Avenue, Orlando 32806.

Toward a Separate State Department of Health

Where does health and the visible health authority stem from and how does it get its authority to the local or county health unit level? Our so-called State Health Officer is one of eight Program Directors in the Department of Health and Rehabilitative Services: a third level area below the Secretary, Deputy Secretary, and Assistant Secretary of Program Planning and Development.

By law, he has no operational, administrative or supervisory authority over public health services. He must route his recommendations first to his own supervisor, the Assistant Secretary for Planning and Development; and then to either the Assistant Secretary for Administrative Services or to the Assistant Secretary for Operations. They, in turn, transmit their orders to the 11 District Administrators where an additional administrative and operational structure exists. The District Administrators, in turn, have operational supervision over the State's 67 county health units.

Such a complicated structure for health leaves no identifiable person with authority or decision-making power, much less accountability for public health services. No one trained in public health fights for health's problems at the national or state level. No skilled health professional can deal quickly and decisively with other state departments on an equal level. Confusion exists among the Department of Environmental Regulation, Department of Administration, Department of Offender Rehabilitation and other agencies as they relate to health. At a higher level, relations with federal health programs are exacerbated without a responsible health department. The Center for Disease Control in Atlanta has refused to send an epidemiologic investigative service officer to serve our state agency. Funding resources from the Department of HEW's Section of Maternal and Child Health, Family Planning, Venereal Disease Control, Hypertensive Cardiovascular Disease, Cancer and other important programs cannot be fully utilized by the Department of HRS.

Further fragmentation of health services can be noted in such statewide programs as tuberculosis control which is now assigned to a district office in Jacksonville. Its relationship with the District Administrator versus the State Health Officer is confusing and unclear. Other statewide programs such as Immunization, Venereal Disease Control, Laboratory Services, Emergency Medical Services, and Radiological Health are all attached to the Central Operations Office of HRS. Their direction and supervision emanates from a nonmedically-trained professional.

A jerry-built organization called HAMLET, an acronym for Health Assistance, Monitoring, Liaison, and Evaluation Team, is another administrative quirk of DHRS. Five of these teams were recently established in key districts throughout the state. Each consists of a physician medical executive, a sanitarian, a nursing consultant, a nutritionist, a health educator and a clerk. Each team, attached to a lead district, acts as a consulting staff for both the District Administrator and the local county health units. However, they have no supervisory, operational or administrative authority. In their table of organization, the medical executive has only the clerk to supervise and acts as some kind of liaison or communication intermediary with the Health Program Office and the county health units. These teams are theoretically supposed to act as the eyes and ears of the Health Program Office in Tallahassee, which is circumscribed into organizational isolation.

Community involvement and the relationship between county commissions and public health at the State level is probably the most important aspect of the difficulties of the reorganization process of DHRS. That this relationship is now severely isolated and strained is evidenced by 13 counties passing resolutions as of 3/28/78 directed to the Legislature requesting a separation of Health from the Department of Health and Rehabilitative Services. The Florida Association of County Health Officers, the Florida Public Health Association, the Duval County Medical Society, the Florida Medical Association, the Environmental Health Association, the Florida Nurses Association, the Florida Council on Community Mental Health, the Florida Dental Association, the Florida Dietetic Association, and other agencies have all gone on record that the best interests of health would be served by separating health from the Department of HRS. The claim has been made that this agitation is created by self-serving specialized health professionals (physicians) who are unhappy with the system because it was not serving their own special interests. The diversity and size of the non-professional group that supports a separate Department of Health contradicts that claim.

An argument has been made by the Secretary of DHRS and the staff of the Planning and Development Section of the Department of HRS that 95% of clients receive multiple services. The computerized Client Information System indicates that only 15.4% are receiving multiple services, nowhere near the 95% claimed.

The Department of HRS is essentially a social

service "client" oriented organization with concentration on services to select individuals. Health service, on the contrary, concerns the whole population. Many important aspects of health have now been lost in the monstrous DHRS organization. Personal health services are only a part of a county health program. A recent cost survey carried out by the Department of HRS for the so-called Core Public Health Program emphasizes this point. Non-personal health services consist of restaurant inspections, food processing inspections, inspections of water plants, swimming pools, trailer parks, sanitary landfills and other important programs in health education, epidemiology and disease control. In terms of dollars, man hours or activities, 52-61% is spent on the above public services vs. individual personal health services. These services statewide require the direction of a skilled trained health professional, not a social service administrator.

The Office of Comprehensive Health Planning has promulgated the argument that creation of a separate Department of Health might create a conflict of interest between proprietors and consumers. Such an argument is specious. Keeping Comprehensive Health Planning in a social agency, however, does maintain an effective "arms-length" relationship now between community medical facilities and agencies. This is unfortunate because lines of communication need desperately to be established with allied health services, local HSAs and the proprietary medical sector.

Only by separating health from the large socially-oriented Department of Health and Rehabilitative Services, and only by establishing a viable line of authority with responsibility and accountability for public health services, then, and only then, will the State of Florida have a public health organization that serves the citizens and visitors in an efficacious and healthful manner.

Submitted by the Committee on Public Health of the Florida Medical Association.

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The Board of Governors of the Florida Medical Association might be compared with the board of directors of a corporation or the board of trustees of a university.

Composed of 18 members from throughout the State, the Board is responsible for carrying out the policies and directives of the House of Delegates, which generally meets only once a year.

By-laws of the Association describe the Board as "the executive body of the House of Delegates." They also charge the Board with a number of responsibilities including the employment of an Executive Vice President and supporting staff; approval of an annual operating budget; responsibility for councils and standing committees; publication of **The Journal** and other functions.

The Board meets at least five times a year — January, March, May, June and October — with special meetings arranged as necessary.

The President of FMA is the presiding officer, and other members include: Vice President; two most recent Past Presidents; President-Elect; Vice President; Secretary; Treasurer; one member each from Medical Districts "A", "B", "C" and "D"; one member selected from the State at Large; the Speaker of the House of Delegates; and one representative each of the Florida delegation to the American Medical Association; the Florida State Board of Medical Examiners; Blue Shield of Florida; the Department of Health and Rehabilitative Services, and the Florida Physicians' Insurance Reciprocal.

The Board has an Executive Committee of seven members which meets more frequently.

The present Board is fairly young, with an average age of about 53. Only one-third of the Board (six members) are native Floridians. Three were born in Ohio and two in New York. The states of Mississippi, Oklahoma, Arkansas, Michigan, West Virginia, Alabama, and North Carolina count one native son each on the Board.

One-third of the Board (six) are family physicians. The next most common specialty is general surgery with four, followed by obstetrics and gynecology and internal medicine with two each. Also, there is one pediatrician, one anesthesiologist, one pathologist and one orthopedic surgeon.

Three Board members are graduates of Duke University Medical School. The University of Miami, University of Arkansas and Tulane each has two of its graduates on the Board. Other Board members are graduates of Harvard, Temple, South Carolina, Michigan, Ohio State, Medical College of Virginia Hahnemann, Jefferson, and Columbia.

As a service to FMA members and so that they may become more familiar with their representatives on the Board of Governors, **The Journal** is pleased to present the following pictures and sketches of Board members.

O. William Davenport, M.D.
Miami



Dr. Davenport

O. William Davenport, M.D., is President of the Florida Medical Association, having assumed that office on May 7, 1978.

Born in Oklahoma and reared in Arkansas, Dr. Davenport now resides in Miami, where he is in the private practice of obstetrics and gynecology.

After service during World War II with the Army Air Corps, Dr. Davenport completed his pre-medical education at Arkansas State Teachers College and received his M.D. degree in 1952 at the University of Arkansas School of Medicine. While there, Dr. Davenport was a founder and served on the first Board of Directors of the Student American Medical Association.

Following medical school, Dr. Davenport received graduate medical training at Baltimore City Hospital. In 1956 he entered the obstetrics and gynecology residency program at the University of Miami and entered practice in that city in 1958. He serves on the volunteer faculty of UM's Department of Obstetrics and Gynecology.

Dr. Davenport is a Past President of the Dade County Medical Association, a Diplomate of the American Board of Obstetrics and Gynecology and a Fellow of the American College of Obstetrics and Gynecology. He also is active in the Southern Medical Association and the Miami and South Central OB-GYN societies, as well as the Florida Obstetric and Gynecologic Society.

Prior to his election as FMA President-Elect in 1977, Dr. Davenport served as Vice President of the Association and earlier, as Chairman of the Council on Scientific Activities.

Richard S. Hodes, M.D.
Tampa



Dr. Hodes

Richard S. Hodes, M.D., of Tampa, occupies the seat of the FMA President-Elect on the Board of Governors. Prior to his elevation to that office last May, he served as FMA Treasurer for three years, during the last of which he also was President of the Hillsborough County Medical Association.

Dr. Hodes is known statewide as a member of the Florida House of Representatives to which he was first elected in 1966 from a Hillsborough County district. Currently the Speaker Pro Tem-Designate of the Florida House, Dr. Hodes has chaired the Committee on Health and Rehabilitative Services and the Committee on Education.

Last July, Dr. Hodes was elected Vice President of the National Conference of State Legislatures.

The President-Elect is a native of New York City and received his M.D. degree in 1946 from Tulane University Medical School. He completed internship at the United States Marine Hospital and a residency at the University of Minnesota before beginning the practice of anesthesiology in Tampa in 1951. He saw service as a U.S. Army Medical Corps Captain.

Dr. Hodes is a member of the volunteer faculties of the University of Florida College of Medicine and the University of South Florida College of Medicine. As a legislator, Dr. Hodes was instrumental in establishing the latter school.

Dr. Hodes is a Past President of the Florida Society of Anesthesiologists and has served on the Board of Trustees of the American Society of Anesthesiologists.

William W. Thompson, M.D.
Ft. Walton Beach



Dr. Thompson

William W. Thompson, M.D., of Ft. Walton Beach, is Vice President of FMA and in his first year of service on the Board of Governors.

Dr. Thompson was born at Hallsboro, N.C., and received both his undergraduate and medical education at Duke University. He received his M.D. degree in 1947.

His graduate medical education included an internship at Mountainside Hospital, Montclair, N.J.; residencies in pediatrics at Duke and Baylor University; and fellowships at Boston Children's Hospital and the Arkansas Allergy Clinic.

During 1949-54, Dr. Thompson served in the U.S. Army Medical Corps in Tokyo, Korea and San Antonio, Texas. He entered the practice of pediatrics at Radford, Va., in 1954, relocating to Ft. Walton Beach in 1956, where he specializes in pediatrics and allergy.

A former mayor of the City of Ft. Walton Beach, Dr. Thompson has maintained an active interest in civic and professional affairs. He served for seven years on the FMA Judicial Council, the last three as Chairman. He currently is serving as President of the Florida Medical Political Action Committee (FLAMPAC).

Dr. Thompson is certified by both the American Board of Pediatrics and the American Board of Allergy and Immunology. He is a member of the Florida Allergy Society and the Florida Pediatric Society and holds life membership in the Southern Medical Association.

He is a Past President of the Okaloosa County Medical Society.

Robert E. Windom, M.D.
Sarasota



Dr. Windom

Robert E. Windom, M.D., of Sarasota, is serving his third one-year term as FMA Secretary.

Born in Columbus, Ohio, Dr. Windom moved to Florida as a youngster. He is a graduate of Duke University in 1952 and of its Medical School in 1956. After a residency in internal medicine at Parkland Memorial Hospital in Dallas, Texas, he established his practice in Sarasota in 1960.

Active in many pursuits, Dr. Windom serves as trustee of New College of the University of South Florida, Chairman of Florida Task Force on Rheumatic Fever and Rheumatic Heart Disease, and on the National Board of the American Heart Association. He is past President of the Florida Heart Association and the Sarasota County Chamber of Commerce.

Prior to becoming Secretary of FMA, Dr. Windom was Chairman of the old Council on Voluntary Health Agencies, the Council on Medical Services, and the Committee on Press, Radio and Television. In Sarasota he co-hosts on a commercial station a weekly 30-minute television program entitled "Medical Viewpoint".

He is a Clinical Associate Professor of Medicine at both the University of South Florida College of Medicine and the University of Miami School of Medicine.

He has received many awards for his service both to the lay and medical communities. These include being named Outstanding Citizen of Sarasota in 1973, and the Distinguished Alumnus Award of Duke University Medical Center in 1977.

Tennis and politics are among his non-medical interests.

J Russell Forlaw, M.D.
Boynton Beach



Dr. Forlaw

J. Russell Forlaw, M.D., of Boynton Beach, is Treasurer of the Florida Medical Association.

He was born in Jacksonville and received his premedical education at Emory University in Atlanta. He was awarded his M.D. degree at the University of Miami School of Medicine in 1956.

After internship at Jacksonville's Duval Medical Center, Dr. Forlaw served a residency at Dade County Hospital. He has been in private family practice at Boynton Beach for the past 20 years.

A Diplomate of the American Board of Family Practice, Dr. Forlaw was President of the Palm Beach County Medical Society in 1968 and Chief of Staff of Bethesda Memorial Hospital in Boynton Beach in 1972-73.

He is a Fellow of the American Academy of Family Physicians and a former President of the Palm Beach County Areawide Health Planning Council.

Dr. Forlaw has served in the FMA House of Delegates since 1968.

He also has served FMA as Chairman of the Committee on Hospital and Extended Care Facilities and the Council on Medical Services.

For relaxation, he enjoys playing golf and tennis.

Louis C. Murray, M.D.
Orlando



Dr. Murray

Louis C. Murray, M.D., of Orlando, is FMA's Immediate Past President.

He was born in New York City, but was reared in Oklahoma, and moved to Florida in 1942 after attending Villanova University for two years. After seeing service in the South Pacific with the U.S. Navy during World War II, Dr. Murray returned to Villanova, where he received his B.S. degree in 1947. He later earned an M.S. degree at the University of Florida and received his M.D. degree in 1953 from Hahnemann Medical College.

He is a family physician in Orlando, and is a Past President of the Florida Academy of Family Physicians.

In 1968, Dr. Murray was President of the Orange County Medical Society. At the state level, he has served as Chairman of the Florida Medical Political Action Committee, the Committee of 17 of the FMA, and the FMA Committee on National Legislation. He has also been a member of the Committee on State Legislation.

Prior to his elevation to the office of FMA President-Elect in 1976, Dr. Murray served as Speaker of the FMA House of Delegates.

For eight years he was a member of the Florida State Board of Regents, and he currently is Chairman of the University of Florida College of Medicine's Dean's Advisory Committee, by virtue of which he is a member of the FMA Committee on Medical Education.

He also has been a member of the Congressional Action Committee of the Orlando Chamber of Commerce and a member of the Board of Directors of the Florida Council on the Blind.

Jack A. MaCris, M.D.
St. Petersburg



Dr. MaCris

Jack A. MaCris, M.D., of St. Petersburg, serves on the Board of Governors as a Past President of FMA, a position he held in 1976-77.

Born in Highland Park, Mich., Dr. MaCris received his M.D. degree from the University of Michigan in 1950. He later earned a Master of Science in Surgery degree at Horace Rockham School of Graduate Studies in Ann Arbor, Mich.

Following internship at Grace Hospital in Detroit and residency training at University Hospital in Ann Arbor, Dr. MaCris moved to Florida, where he began the practice of general and vascular surgery.

Dr. MaCris has filled leadership roles in the FMA for many years. He has served on the Executive Committee, Board of Governors, Committee of 17, and the Council on Medical Economics. In the early 1970s, he was a founder and the Vice President of the Florida Physicians Association. He also was a founding member and Past President of the Florida Association of General Surgeons, a Past President of the Pinellas County Medical Society, and a Past President of the Florida Chapter of the American College of Surgeons. He is a Diplomate of the American Board of Surgery.

Dr. MaCris also has served on the Board of Directors of Blue Shield of Florida, and as a Council member of the Frederick A. Coller Surgical Society. Other professional memberships include the Southeastern Surgical Congress and the American Medical Association.

During World War II, Dr. MaCris served in the Navy for two years, including duty as a line officer aboard a heavy cruiser.

In his spare time he enjoys golf, fishing and swimming.

Sanford A. Mullen, M.D.
Jacksonville



Dr. Mullen

Sanford A. Mullen, M.D., of Jacksonville, is serving his first term as Speaker of the FMA House of Delegates.

A native of Tampa, Dr. Mullen received his M.D. degree in 1949 from Columbia University's College of Physicians and Surgeons. He served an internship at Grady Memorial Hospital in Atlanta, and received training in pathology at Grady and at the University of Minnesota Hospital.

A Diplomate of the American Board of Pathology in clinical pathology, anatomic pathology and blood banking, Dr. Mullen is Executive Vice President and Medical Director of the Jacksonville Blood Bank. He is also co-chief of the Department of Pathology at University Hospital of Jacksonville and is Clinical Associate Professor of Pathology at the University of Florida (JHEP).

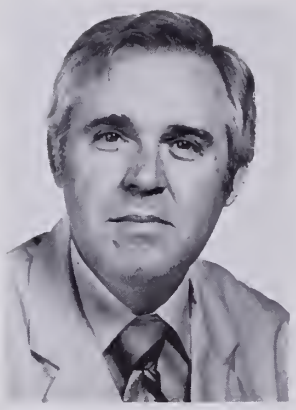
For many years he has been an active participant in professional and civic affairs. He received, in 1973, the A.H. Robins Company Award for Outstanding Community Service by a Physician.

He has held many offices and appointments in the Duval County Medical Society, including the presidency. He also has been President of the Florida Society of Pathologists, the Florida Association of Blood Banks, the Jacksonville Experimental Health Delivery System and the Jacksonville Rotary Club. He is a former member of the Executive Committee and Board of Governors of the College of American Pathologists.

He has served the Florida Medical Association as Chairman of the Committee on Pathology, the Council on Specialty Medicine, the Committee on State Legislation, and the Council on Legislation and Regulation; and as Vice Speaker of the House of Delegates.

He relaxes with an occasional game of golf, and is an avid reader with a particular interest in novels, biographies and history. His record collection is rich in "Big Band Era" music.

J. Lee Dockery, M.D.
Gainesville



Dr. Dockery

J. Lee Dockery, M.D., of Gainesville, is serving the first year of a four-year term on the Board of Governors representing Medical District "A."

Dr. Dockery was born in Amity, Ark., received a B.S. degree in medicine from the University of Arkansas at Fayetteville, and his M.D. from the University of Arkansas School of Medicine, Little Rock. He then came to Florida, where he took an internship and a residency in obstetrics and gynecology at Miami's Jackson Memorial Hospital.

He was engaged in the private practice of obstetrics and gynecology until 1975, when he moved to Gainesville to join the faculty of the University of Florida College of Medicine. He is Associate Professor of Obstetrics and Gynecology, and since September 1, he has been Associate Dean of the College for Academic Affairs.

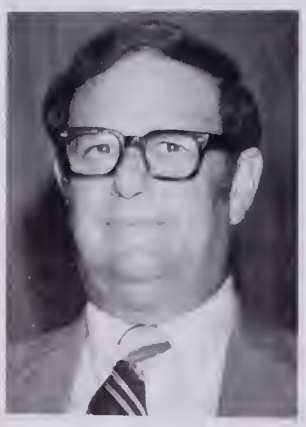
In 1974-75, Dr. Dockery served on the FMA Board of Governors, and was FMA Vice President in 1977-78. He was appointed to a four-year term on the Board this year. He has served FMA in many other ways, including member of the Membership and Discipline Committee, and Chairman of the Council on Scientific Activities.

A Diplomate of the American Board of Obstetrics and Gynecology and a Fellow of the College, Dr. Dockery also is a member of the Alachua County Medical Society, the American Medical Association and the Florida Obstetric and Gynecologic Society. He was Program Chairman for the AMA Mid-Winter Scientific Meeting in Miami Beach last December, and is Florida Section Program Chairman for the American College of Obstetricians and Gynecologists.

As a faculty member, Dr. Dockery received the Outstanding Clinical Science Award at the University of Florida College of Medicine in 1977, and the Teacher of the Year Award this year.

Among his favorite pastimes are fishing, tennis and travel.

Charles J. Kahn, M.D.
Pensacola



Dr. Kahn

Charles J. Kahn, M.D., of Pensacola, is serving a one-year term on the Board of Directors as the at-large appointee.

Dr. Kahn was born in Pensacola, and attended Tulane University, where he received a B.S. degree in 1946 and his M.D. in 1950. He interned at Charity Hospital in New Orleans and took residency training at Brooke Army Medical Center and the old Duval Medical Center in Jacksonville.

He has practiced internal medicine in Pensacola since 1955. He served twice in the armed forces, first during 1943-46, then as an Army Medical Corps Captain in 1950-53.

Dr. Kahn is a member of the Escambia County Medical Society, the American Medical Association and the American Geriatric Society. He is a Past President of the West Florida Academy of Medicine. He also has served as a Director of the Florida Heart Association.

He has served as a member of the Committee on Aging of the FMA and is a former Vice Speaker and Speaker of the FMA House of Delegates.

He formerly headed the Pensacola Education Program and more recently has been Chairman of Florida's Community Hospital Education Council.

Norman M. Kenyon, M.D.
Miami



Dr. Kenyon

Norman M. Kenyon, M.D., of Miami, represents Medical District "D" on the Board of Governors.

Born in Clearwater, Dr. Kenyon attended St. Petersburg Junior College and Emory University of Atlanta. He recieved his M.D. degree in 1956 from the University of Miami School of Medicine, where he had the distinction of being the President of the first graduating class.

Dr. Kenyon served an internship at John Gaston Hospital in Memphis, Tenn., but returned to Miami for a general surgery residency at Jackson Memorial Hospital. In the 1960s, he served as a Captain in the U.S. Army Medical Corps.

Dr. Kenyon is a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons. He has served as President of the Miami Chapter of the ACS and is President-Elect of the Florida Chapter.

An Assistant Editor of **The Journal,** Dr. Kenyon is a member of the Dade County Medical Association, the American Medical Association, the Southeastern Surgical Congress and the Southern Medical Association. He has served on the Executive Committee and as Chairman of the Ethics Committee and the General Health Insurance Committee of his county society.

He is Clinical Assistant Professor of Surgery at the University of Miami School of Medicine and has served as President of the School's Alumni Association. He is the author of several publications on lymphangiography, tetanus, gas gangrene, and hyperthermy.

For recreation, the Miami surgeon enjoys tennis, boating, and fishing. He is a "Master Angler" at Miami's Rod and Reel Club.

Donald G. Nikolaus, M.D.
Dunedin



Dr. Nikolaus

Donald G. Nikolaus, M.D., of Dunedin, represents Medical District "B" on the Board of Governors.

The Ohio native was valedictorian of his high school graduating class at Johnsville, Ohio; and of his college graduating class at Ashland (Ohio) College. He received his M.D. degree cum laude from the Ohio State University Medical School in 1955. His internship was at Mound Park Hospital in St. Petersburg.

Dr. Nikolaus joined the Mease Clinic staff in Dunedin in 1956, took two years out to serve as an Air Force Flight Surgeon, and returned to Mease in 1958.

He is active in the Pinellas County Medical Society, which he has served in many roles including a year as President. He also is a former President of the Florida Academy of Family Physicians.

Dr. Nikolaus has held several positions in the American Academy of Family Physicians, including Chairman of the Cancer Committee; member of the Commission on Public Health and Scientific Affairs; liaison with the National Safety Council Home Conference and Auto Safety; and Chairman of the Subcommittee on Optimum Health Care.

For the American Cancer Society he has served on the Professional Education Committee and the National Task Force on Breast Cancer.

This year Dr. Nikolaus was one of the national finalists in Good Housekeeping Magazine's Family Doctor of the Year Search.

Dr. Nikolaus spends some of his free time fishing, playing tennis and horseback riding.

Thomas B. Thames, M.D.
Orlando



Dr. Thames

Thomas B. Thames, M.D., of Orlando, occupies the Medical District "C" seat on the Board of Governors. He also is a member of the Executive Committee of the Board.

Dr. Thames was born in Alabama, attended the University of Florida and received his M.D. degree from Duke University School of Medicine in 1955. He interned at Duke and at Walter Reed Army Hospital.

He served two years as a Flight Surgeon in the U.S. Air Force and joined the medical staff of the Orlando Clinic in 1958.

Dr. Thames has served as President of the Orange County Medical Society, the Florida Industrial Medical Association and the Florida Academy of Family Physicians. He is one of Florida's Alternate Delegates to the American Medical Association and also is a member of the AMA Speakers Bureau.

He is Medical Director for several concerns, including Walt Disney World.

Active in civic affairs, Dr. Thames is a former President of the Orlando Rotary Club, a member of the Central Florida Development Committee and of the Committee of 100.

His wife, Patricia Lee Thames, is currently the President of the FMA Auxiliary.

For recreation, Dr. Thames enjoys hunting, fishing and tennis.

Vernon B. Astler, M.D.
Delray Beach



Dr. Astler

Vernon B. Astler, M.D., of Delray Beach, serves on the Board as a representative of the Florida Physicians' Insurance Reciprocal Board of Directors. He also has served as the FMA's Public Relations Officer for the past three years.

A native of Ohio, Dr. Astler is of the fourth generation of a family of physicians. His great grandfather, grandmother, grandfather, father and uncle were physicians.

Dr. Astler received his M.D. degree in 1949 from Temple University School of Medicine, and took internship and surgical residency training at the University Hospital in Ann Arbor, Mich. During the Korean War, he saw service in Japan and Korea as a U.S. Army Medical Corps Captain.

During the Annual Meeting of 1974, Dr. Astler was elected the Association's 99th President, and he began his one-year term in 1975. During 1976, he was instrumental in the establishment of the FMA's new public relations program and he has guided it ever since.

For eight years Dr. Astler sat on the Florida State Board of Medical Examiners and served as the Board's President for two years.

He has practiced general and vascular surgery at Boynton Beach, Palm Beach County, since 1956.

A Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons, Dr. Astler holds several other professional memberships, including the Florida Association of General Surgeons, the F.A. Coller Surgical Society, the Pan American Surgical Association, and the Southeastern Surgical Congress. He is a member of the Florida Council of 100.

A man of many interests, Dr. Astler relaxes with golf, tennis, hunting, fishing, flying and amateur photography.

Rufus K. Broadaway, M.D.
Miami



Dr. Broadaway

Rufus K. Broadaway, M.D., of Miami, represents FMA's delegation to the American Medical Association on the Board.

He was born at Jackson, Miss., and received his M.D. degree in 1950 from Harvard Medical School. His graduate medical education was received at Mary Imogene Bassett Hospital, Cooperstown, N.Y.; and Presbyterian Hospital, New York City.

Professionally, Dr. Broadaway is a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons. He is a Past President of the Dade County Medical Association and is a member of the Southeastern Medical Association and the Southern Surgical Congress, among others.

Long interested in medical education, Dr. Broadaway has served as Director of Postgraduate Medical Education at Miami's Cedars of Lebanon Hospital and is Chief of Surgery there. Since 1970, he has held appointment as Clinical Professor of Surgery at the University of Miami School of Medicine.

His other professional activities have included the editorship of the Dade County Medical Association Bulletin; district director of the Florida Regional Medical Program, Board of Directors of the Comprehensive Health Planning Council of South Florida; and Dean's Advisory Committee and Long-Range Planning Committee of the University of Miami School of Medicine. He is Chairman of the Council on Long-Range Planning and Development of the American Medical Association.

A long-distance runner, Dr. Broadaway turned in a time of 3:16 in the 1978 Boston Marathon. He also enjoys swimming, photography, reading, back-packing, climbing and camping.

Ben M. Cole, M.D.
Orlando



Dr. Cole

Ben M. Cole, M.D., of Orlando, represents the Florida State Board of Medical Examiners on the Board of Governors.

Dr. Cole was born in Jacksonville but spent most of his early years in South Carolina, where he attended Clemson, as well as the state university. He received his M.D. degree in 1950 from the Medical University of South Carolina.

After a one-year internship at Orlando's Orange Memorial Hospital, Dr. Cole entered family practice in Orlando, where he has been located ever since.

Over the years, Dr. Cole has been an active member of the American Academy of Family Physicians, the Orange County Medical Society, the Florida Medical Association and the American Medical Association. He is a former member of the Board of Directors of the Florida Academy of Family Physicians and a former member of the Executive Committee of the Orange County Medical Society.

He served one term as Chief of Staff of Orange Memorial Hospital, and received his first appointment to the Board of Medical Examiners in 1973. In 1977, he was President of the Board of Medical Examiners.

Dr. Cole is a man of diverse leisure time pursuits. He keeps about 20 bee hives and does the honey extraction himself.

A boating enthusiast, Dr. Cole likes to tinker with all types of vehicles, including cars, boats and tractors.

In addition, he builds and refinishes furniture and likes machine shop activities, including working with a metal lathe.

Joseph G. Matthews, M.D.
Orlando



Dr. Matthews

Joseph G. Matthews, M.D., of Orlando, serves on the FMA Board of Governors and as Chairman of the Board of Directors of Blue Shield of Florida.

He received his A.B. and B.S. degrees from West Virginia University and his M.D. degree from Jefferson Medical College in 1952. He received his internship and residency at Orange Memorial Hospital and later became Chairman of the Department of Orthopaedics for six years.

During World War II, he served in the South pacific for 31 months as a 13th Air Force photographer.

Dr. Matthews is a Diplomate of the American Board of Orthopaedic Surgery, and a Fellow of the American Academy of Orthopaedic Surgeons, in which he is a member of the Regional Admissions Committee. He is a charter member of the Jefferson Orthopedic Society and Citrus Orthopedic Society. He has served as medical advisor to the Florida Physical Therapy Association for seven years, and as medical director of Children's Medical Services, District 7, for 10 years. He is an honorary member of the Florida Pediatric Society.

Dr. Matthews has been a member of the FMA Board of Governors for five years; and has been Chairman of the FMA Council on Specialty Medicine for three years; an FMA delegate for three years; Assistant Editor of **The Journal of the Florida Medical Association** for three years; a member of the FMA Committee on Relative Value Studies for four years; and a member of the Ad Hoc Committee on Workmen's Compensation for four years. He chaired the Committee for Structure Study of the FMA in 1971.

His hobbies are flying and photography.

Eugene G. Peek Jr., M.D.
Ocala



Dr. Peek

Eugene G. Peek Jr., M.D., of Ocala, has represented the Florida Department of Health and Rehabilitative Services (formerly the State Board of Health) on the Board of Governors for many years.

Dr. Peek was born in Ocala, attended Stetson University and the University of Florida, and received B.S. and M.S. degrees from the University of Richmond. He earned his M.D. degree at the Medical College of Virginia in 1944. He interned at MCV and served a surgical residency at St. Elizabeth's Hospital in Richmond, Va.

He practiced briefly in Ocala in 1946 and re-established his practice there permanently after two years of service as a U.S. Army Medical Corps Captain.

Dr. Peek's late father was President of FMA in 1943. The younger Dr. Peek has held many positions of responsibility in FMA, including Vice Speaker and Speaker of the House of Delegates and Vice President of FMA. He has served as President of the Florida Medical Foundation and was President of the old State Board of Health.

In 1969, FMA awarded Dr. Peek its highest honor, the Certificate of Merit. Three years later he received the Meritorious Service Award of the Florida Public Health Association.

The Ocala physician is an alternate delegate to the American Medical Association. He is a Past President of the Marion County Medical Society and has served on the Board of Directors of the Florida Academy of Family Physicians. Other professional memberships include the American Academy of Family Physicians, the Southern Medical Association, the Southeastern Surgical Congress, and life membership in the American Medical Society of Vienna.

JFMA Poisonous Plants Issue Wins State Magazine Award

The Journal's Special Issue on Adverse Reactions to Plants in Florida was named the Best Special Issue in the 22nd Annual Magazine Awards Contest sponsored by the Florida Magazine Association.

Assistant Editor Richard C. Dever, M.D., and Managing Editor Louise Rader, both of Jacksonville, received the award at the Association's Annual Awards Banquet in Tampa on September 9.

Laudie McHenry, M.D., and Philip Blank, M.D., both of Melbourne, served as Guest Editor and Guest Co-Editor, respectively, for the issue that was published in March, 1978.

It marked the third consecutive year *The Journal* was the recipient of the Best Special Issue Award in this contest. It won previously with special issues on dermatology and neurosurgery.

In a critique booklet distributed at the Awards Banquet, the judges had this to say about the winning special issue:

"A thoroughly professional job by all involved. The inside pages deliver exactly what is promised on the cover, namely, a special issue on 'Adverse Reactions to Plants.' And talk about service to the reader—this one has it! The articles are well written and concise, the illustrations useful and the layout neat and inviting. A thoroughly professional job. Well done!"

The judges had complimentary comments about JFMA's special issue on "Medicine and the Cuban Physician," which was among 25 other entries in the Best Special Issue category. However, it did not win an award.

The Journal also received a Certificate of Merit for General Excellence among non-profit association publications with circulation under 18,000.

The Journal's Executive Editor Heads State Magazine Association

Edward D. Hagan of Jacksonville, Executive Editor of *The Journal,* has been installed as President of the Florida Magazine Association.

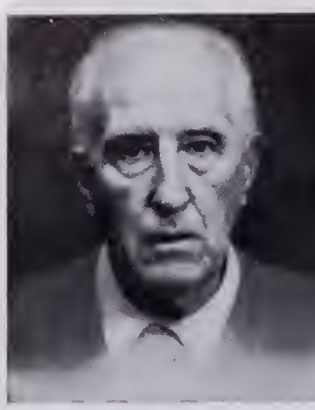
The election and installation took place at the Association's 26th Annual Meeting in Tampa on September 9.

The Florida Magazine Association is an organization of editors and publishers of about 90 periodicals published in Florida. The group includes trade and professional journals, city and society magazines, employee publications, special interest magazines and others.

A member of the association since 1973, Mr. Hagan has served on the organization's Board of Directors for two years, most recently as Vice President.

A native of Morgantown, W. Va., and an honor graduate of Marshall University, Mr. Hagan joined the staff of the Florida Medical Association in 1970 as Director of Communications. In addition to his responsibilities with *The Journal,* he is Director of Scientific Activities for FMA.

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PRECAUTIONS: Use with caution in patients with low convulsive threshold, focal brain lesions, severely impaired liver function, peptic ulcer, diabetes, and gall bladder or liver diseases. Niacin may potentiate hypotensive drugs, phenothiazine derivatives and inactivate fibrinolysin.
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WANTED FOR CONSUMER EDUCATION PROGRAM — Physician with broad experience in the treatment of pain to travel part-time for major producer of analgesics. Provide consumer information on pain and fever management through TV, radio and newspaper interviews. Spring 1979 program would call for approximately ten trips of two days each to large cities. Ideal project for retiree, or author of articles on related subject.

Please respond to C-891, Box 2411, Jacksonville, Florida 32203.



Newton C. McCollough III, M.D. . . . has been named Professor and Chairman of the Department of Orthopaedics and Rehabilitation at the University of Miami School of Medicine and chief of service at Jackson Memorial Hospital.

He had served in these positions in an acting capacity since last February. A native of Pennsylvania, Dr. McCollough received his M.D. degree from the University of Pennsylvania in 1959 and received internship and residency training in general surgery and orthopedic surgery at Jackson and at Variety Children's Hospital.

A Tallahassee physician . . . is participating in a program being distributed by the Network for Continuing Medical Education in October.

The program is called "The Automobile Casualty", with Thomas J. Bixler, M.D., Chairman of the Department of Emergency Medicine at Tallahassee Memorial Hospital. The telecourse will be conducted October 16-29.

The program is a guide to initial emergency room treatment of the multiple-injured patient and is acceptable for AMA Category I Credit, American Academy of Family Physicians Prescribed Credit, and FMA Mandatory Credit.

1979 FMA Annual Meeting . . . "Nutrition" will be the theme for the 105th Annual Meeting of the Florida Medical Association. The sessions are scheduled for Wednesday through Sunday, May 23-27, 1979, at the Diplomat Hotel in Hollywood.

Annual Meeting Scientific Program Chairman Henry M. Yonge, M.D., of Pensacola, said a special symposium on nutrition is being arranged by FMA's Ad Hoc Committee on Nutrition for Thursday afternoon, May 24.

As in recent years, the initial scientific session will be on Wednesday afternoon. Other scientific meetings will be on Thursday afternoon, Friday and Saturday mornings and afternoons.

FMA-recognized specialty groups have been asked to have their programs completed by October 1. The early-bird this year was the Section on Chest Medicine, for which all arrangements were completed in mid-August.

Specialty groups have been asked to consider integrating the nutrition theme into their section programs by including one or two talks on the subject.

The FMA Committee on Continuing Medical Education is accepting applications for scientific and educational exhibit space at the Annual Meeting. An application form was included in Issue No. 259 of "Briefs," which was mailed to FMA members in August.

The 10th Annual Joint Meeting . . . of the Florida Society of Internal Medicine and the Florida Region of the American College of Physicians will be held at the Breakers Hotel in Palm Beach, October 13-15.

Eugene R. Schiff, M.D., Chief of Hepatology at the University of Miami School of Medicine, is Program Chairman. Information may be obtained by contacting Charles K. Donegan, M.D., 501 Eleventh Street North, St. Petersburg, Fla. 33705.

Tallahassee Attorney Richard C. McFarlain . . . has been appointed prosecuting attorney for the Florida State Board of Medical Examiners.

The appointment, made in August, is for a six-month trial basis. The addition of Mr. McFarlain to the staff will enable BME Legal Counsel Michael I. Schwartz to concentrate on advisory duties.

Mr. McFarlain has been in private law practice for two years, and for 11 years prior to that he was on the full-time staff of the Florida Bar, engaged primarily in directing disciplinary proceedings.

Vote For
Constitutional Amendment #1
Separate Department of Health

Deaths

Aldereguia, Emilio Ramon, Miami; born 1930; University of Havana, 1954; member AMA; died May 22, 1978.

Boyer, Samuel H., Hallandale; born 1910; Tufts University, 1936; member AMA; died April 30, 1978.

Cluxton, John F., Panama City; born 1933; University of Florida Medical School, 1960; died May 25, 1978.

Cordrey, Lee J., Tampa; born 1921; Temple University Medical School, 1945; member AMA; died June 30, 1978.

DeVito, James J., Hailey, Idaho; born 1920; Boston College of Physicians and Surgeons, 1948; member AMA; died June 12, 1978.

Highsmith, George F., Arcadia; born 1885; University College of Medicine, 1912; member AMA; died January 30, 1978.

House, Curtis R., Fort Myers; born 1912; Tulane School of Medicine, 1942; member AMA; died April 20, 1978.

Levin, Alfred G., Miami; born 1905; University of Minnesota, 1930; member AMA; died May 31, 1978.

Lowry, Blackburn W., Tampa; born 1895; Northwestern University, 1919; member AMA; died May 8, 1978.

Pitts, Robert O., Sarasota; born 1919; Vanderbilt University, 1943; member AMA; died June 15, 1978.

Roberts, Henry Lamar, Ocala; born 1919; Duke University, 1944; member AMA; died July 5, 1978.

Shalloway, Charles Leon, Hialeah; born 1914; Emory University, 1939; member AMA; died June 9, 1978.

Tubbs, Frederick E., Merritt Island; born 1935; Emory University, 1961; died July 4, 1978.

Criticism comes easier than craftmanship.

Plato

BRIEF SUMMARY OF
PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

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When you're good people recognize you.

Highly effective
Single-dose convenience
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Antiminth®
(pyrantel pamoate)
equivalent to 50 mg pyrantel/ml
ORAL SUSPENSION



a drug of choice in pinworm infections

Please see brief summary of prescribing information on facing page.

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When painful spasm
is the presenting
symptom...

. . . in functional G.I. disorders*

Bentyl®

(dicyclomine hydrochloride USP)

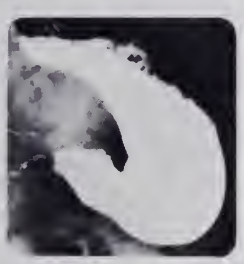
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964

Merrell

8-3497 (Y515A)

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION.

Brief Summary
INDICATIONS
For use as adjunctive therapy in the treatment of peptic ulcer.
IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION.

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy; hepatic or renal disease; ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS. Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache, nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.
Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
Product information as of October, 1976

Merrell
MERRELL-NATIONAL LABORATORIES
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Cincinnati, Ohio 45215, U.S.A.

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Your Business can be one too.

Red Cross needs individual volunteers, and donors of blood and money, by the millions.

But we need even more help. We need the solid support of American Business. And we never needed it more.

If your business is already helping, by organizing blood drives, and by supporting payroll deductions—either directly for the Red Cross, or through the local combined fund drive—the whole community owes you thanks. And we thank you, too.

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Think of America without The American Red Cross.

And you'll know why we need your business as a Red Cross Volunteer. In your community. And all across America. Contact your local Red Cross Chapter to see how your company can become a volunteer.

Red Cross is counting on you.



Others Are Saying

Precious Cargo

Julia R. St. Petery, M.D.

Despite commendable efforts in education, engineering and legislation, automobiles remain today's number one child killer. Accidents cause the death of more children than any disease process does, and automobile accidents cause the overwhelming majority of accidental deaths in this age group. In the past 10 years more than 10,000 children under the age of five were killed in highway crashes. Additionally, there are approximately 40 injuries for every death sustained. Many of these injuries are not only serious but permanent and handicapping.

While death rates from infectious diseases and other causes in children under four years have declined markedly in the past 20 years, death rates from accidents have remained relatively unchanged. As an example, in 1973, 116 Americans (including all age groups) died from the usual childhood diseases such as measles, mumps, polio, diphtheria, whooping cough and tetanus. In the same year approximately 1,080 children between the ages of 1 and 4 died in automobile accidents. This means that the number of small children who died in automobile accidents in 1973 was about 10 times greater than the number of people of *all* ages who died from "common" infectious diseases.

A survey on the use of child restraints revealed that out of some 9,000 cars observed in which a child aged 10 years or less was a passenger, only 25% of the adults were using restraints, and only 7% of the children were properly restrained. Where child restraint devices were present 16% were not in use and 73% of those used were inadequate or incorrectly used.

Why don't parents use appropriate restraints for children? Some persons still cling to the popular belief that small children are more often killed outside of the vehicle than inside. This simply is not true. Perhaps many parents are unaware that while their arms are safe and secure places for their children most of the time, their arms are not safe for carrying a child or infant inside a car. A crash may generate such force that no parent can continue to hold the child securely. Additionally, if the adult is unrestrained, crash forces similarly multiply his weight and may fling him against the child with crushing force.

Unfortunately, there are products advertised as infant car carriers or car beds which, while useful in the house, are totally inadequate inside cars. While the hookover baby seats were outlawed for manufacture after 1972, they may still be sold, and a significant number of such grossly inadequate carriers remain in use.

Some say the cost of child restraints is a deterrent, but in reality the cost is relatively low. There are families who cannot afford $30 or $40 for a restraint. Yet, often these same families are even less able to afford the horrendous medical expenses of a crash injury. Regardless of income, our priorities seem confused when some parents will spend thousands of dollars for a new car, spend hundreds of dollars on extra equipment such as tape decks and F/M radios for the car, and then totally neglect to invest $40 or less for a restraint that could save their child's life.

When automobile manufacturers are asked why they do not widely advertise restraint devices, they blame public apathy. It is perplexing when one contemplates the extraordinary public reaction to infectious diseases such as the swine flu threat and Legionnaires disease. The public, the medical profession and the government respond to these challenges immediately (occasionally over-reacting, in some opinions) and demand methods to protect or immunize themselves and their children against these threats. The lack of public and parental outcry and demand for adequate preventive measures against the biggest killer of children is further puzzling because there seems to be reasonable distribution of the information that the use of appropriate restraints significantly decreases the chances of serious injury and death in automobile accidents.

Projections of potential human and economic savings by the National Highway Traffic Safety Administration in 1975 demonstrate that the number of deaths and injuries that could be prevented by seat belt use are exceeded only by the extraordinary cost incurred by these accidents. It is estimated that appropriate use of crash-tested devices on children under the age of five could save 91% of lives lost and reduce injuries by 78%.

Another problem is that adult devices, i.e. lap belts are not appropriate for infants and small children. The small child is not a miniature reproduction of an adult. Anatomically and emotionally, the young child's differences from adults make particular restraining devices necessary to adequately protect in crashes. A child should not be considered a scaled-down adult for the purposes of designing automobile restraints for reasons such as the following:

1. The child's head is proportionately much heavier and larger than the adult's when compared to relative body size.
2. The child's head is supported by much weaker neck muscles and other structures than the adult's.
3. The child's bones are incompletely developed. The anterior iliac spines (the pointy bone at the front of your hip) are anatomical anchor points for standard lap belts; in children, those bony protuberances are not well developed until 10 years of age.
4. The lack of anterior spines combined with the bulges of flesh in the pelvic region make the correct positioning of a lap belt difficult and under impact would allow the belt to rise up into the abdomen causing severe internal injuries.
5. The child has a relatively higher center of gravity than the adult, predisposing the child to whip forward more violently than the adult.

Small children require protection which distributes the force of impact over a larger body area than permitted by shoulder harnesses and lap belts. Children under 40 pounds (18 kilograms) and under four years of age should utilize special restraints. Children under five feet tall should not use shoulder straps because these straps are likely to cross their necks or faces with the potential for serious injury under crash circumstances. Children who are larger than these parameters should utilize available lap belts and harness. A firm cushion no more than two inches high will allow the child better visibility with subsequent improved satisfaction on the child's part. Under no circumstances should two children be strapped into one seat belt, nor should shoulder straps be used without the lap belt.

Attempts to regulate safety standards are a problem. Present regulations, promulgated for and by adults, are appropriate for adults, but they overlook or even exclude standards for small children.

Consumers Union has published the results of simulated crash testing of 17 restraint devices, all meeting government specifications; 12 of 17 were unacceptable under dynamic testing because they collapsed and/or pivoted and slammed the occupant's head forward.

Let's look at the features of devices found acceptable in crash testing: there are basically four such devices.

1. Infant carrier
2. Traditional car seat with harness
3. Harness alone
4. Shield

Consumers Union also has pointed out the obvious but often overlooked fact that cost, convenience, and child acceptance are important factors in addition to structural design. *Safe devices* are useless if not used and used properly.

Reprinted from ACCESS Magazine, April/May, 1978.

One speech usually ends up being three;
the one you write, the one you actually give,
and the one you wish you had given.

The Battle Over Regulating Multiphasic Test Centers

If political bargaining is the art of the possible, you won't see a better example than a Florida doctor's experience in getting a state licensing law passed.

Philip Harsham
Senior Editor, Medical Economics

Solo internist David J. Lehman Jr. is also Florida State Representative David J. Lehman Jr. Because of his time and attention that his seat in the Legislature demands, Lehman's medical practice has dwindled by 30 to 40 percent over the last three years, with his income dropping accordingly. Still, he feels that his second career is worth the inroads it makes into his first. "More physicians should be taking active roles in government," Lehman declares. "They would find it highly rewarding."

They might find it a bit frustrating, too, he concedes. That's because political positions are seldom black and white — more often they're compromise gray.

A prime example is the inside story of Florida law CSHB371, bureaucratese that translates into Committee Substitute for House Bill 371. Passed by the 1977 Legislature, it's the first state law designed to license and regulate the highly advertised multiphasic health-test centers that have spread across the country.

Lehman drafted the bill and shepherded it through the legislative maze, undertaking that task as something of a crusader. He found it expedient during the process to compromise with the "enemy" — a lesson in political realism that might well be taken to heart by any physician who's eyeing a political career (or any who might wonder how Congress will deal with national health insurance). The result, nonetheless, was a model bill that not only cleared up the abuses at which it aimed, but left open a medical option that many patients seem to want. Now legislative and medical interests in other states — even other countries — are studying it for possible adaptation to their own health-care needs.

The Florida health-test centers, conceived by William Zibell, a New Jersey entrepreneur who'd moved south as a real-estate dealer, made their debut a couple of years ago in and around Fort Lauderdale in Broward County. Operated purely as businesses often from storefront locations, they almost immediately created an uproar within the medical community. And they spread fast.

Charging $25 to $30 a visit, these centers typically provide a series of blood tests, an electrocardiogram, urinalysis, and pulmonary function tests. They routinely measure blood pressure, pulse, respiration, temperature, weight, and height. Some include screening for hearing and vision defects. More than a dozen were opened in Broward County the first year, and founder Zibell estimates that some 400 others are scattered around the country. Zibell, who's president of the National Association for Health Testing, an organization of test center operators, claims credit for much of that spread . His company, American Health Association, sells franchises for the centers and a year ago was opening them, he says, at the rate of one a week.

Nowhere were the centers regulated. Operators of those in Florida, where the centers were most heavily concentrated, needed only a city occupational license until Lehman's bill was passed. Now as a result of CSHB371, Florida centers must be inspected at least annually and licensed (at a minimum fee of $300) by the State Department of Health and Rehabilitative Services. The centers' advertising, often flamboyant in the past, now must include this notice: "Health-screening tests *may* or *may not* alert you and your doctor to serious medical problems and are *not* intended to be a substitute for a physician's examination." Each center must employ a medical director, a licensed M.D. or D.O. who interprets ECGs as part of his regular practice. The director may do the interpretations in his own office, but he is forbidden to diagnose, treat, or offer consultations to the center's clients.

Lehman first became interested in the multiphasic test centers when the husband of one of his longtime patients reluctantly appeared at his Hollywood office for a physical exam. He hadn't been feeling quite up to snuff, the man said, but he certainly didn't need a doctor — despite his wife's insistence that he see Lehman. He'd just had "a complete checkup" at one of the new test centers, in fact, and "passed" easily. Lehman proceeded with the examination, nevertheless, and came up with a report considerably less cheerful. His diagnosis: rectal carcinoma.

Lehman was outraged. Bad enough that the largely automated tests had failed to pick up the malignancy. But even worse, they'd deluded the patient into thinking that he was all right, lulling him into complacency while the malignancy worsened.

About the same time, a conflict was developing between the health-test centers and the 1,200-member Broward County Medical Association. The association contended that the centers were practicing medicine without a license and that physicians could not accept their medically unsupervised test results because "their accuracy is suspect."

Association members were warned that accepting test results from the centers could leave them open to malpractice suits. They also might choose to align themselves with the centers — perhaps as medical directors — might be subject to censure by the medical association.

The centers countered with a charge that the physicians' opposition ws financially motivated — that a doctor's total fee for tests, a history, and physical exam was at least five times as much as the charge for tests alone at the centers and that doctors simply feared the low-cost competition. The centers also pointed out that the specimens they collected for testing were sent for analysis to the very same clinical laboratories that many of the physicians used — as indeed they were. Zibell, acting for the National Association for Health Testing, threatened suit against the medical association and Lehman, charging violation of the Sherman antitrust law. That suit was dropped once the heat of battle subsided.

In August, 1976, the medical association asked Florida's Governor Askew and the Legislature to look into the centers. Subsequently, the House Health and Rehabilitative Services committee was told to undertake a preliminary investigation with an eye toward drawing up regulatory legislation. Representative Lehman — the committee's vice chairman as well as a practicing physician — was the logical choice to head it.

"To me," says Lehman, "this was to be consumer legislation. We had to try to protect people — mostly the elderly — who were going through these centers with the idea that they were getting a complete physical examination for $25 or $30. The centers were claiming that licensed physicians interpreted their ECGs and examined the test results returned by clinical labs. But some centers were paying doctors for the use of their names and the doctors never went near the places. Test results were simply labeled either normal or abnormal.

"The people undergoing these tests think they're establishing a doctor-patient relationship. Now what happens if one of them needs a doctor at 3 a.m.? Is that guy who signed his test results going to look after him? When he's signing maybe 80 a day?

"That's the real danger. These places were advertising themselves as substitutes for physicians, and they are not. The tests themselves may be fine. But unless there's a doctor interpreting them and relating them to a patient he has examined and whose medical history he knows, they're worthless."

Lehman, who had just been elected to his second term in the Legislature, soon found out that the assignment he'd been given was to be no snap. There were no applicable statutes on which he could model his bill, no guidelines of any kind. The chairman of the counterpart Health and Rehabilitative Services committee in the Senate flatteringly compounded the problem: He told Lehman to go ahead and draft a bill, and he would simply introduce an exact companion in the Senate.

Lehman at first considered bringing the test centers under an existing statute that regulates clinical laboratories. That would have required them to refrain from advertising and to submit their test results to clients only through licensed medical practitioners. Having to abide by those requirements, the test centers very likely would have faded away. But after conferring with various civic groups, Lehman concluded that there was considerable demand for the centers' service; indeed, they might well alert clients to some hidden diseases. Too, true consumer legislation must preserve the individual's freedom of choice. "There would be those who chose to stick out their arms to test-center technicians rather than pay physicians for a thorough physical, and they should be allowed the right to do so," he says.

Toward that end, Lehman decided to confer with his primary adversary, Zibell. Together, they threshed through both sides of the controversy, and Lehman roughed out a bill satisfactory to both, essentially the bill that passed.

But even with Zibell's cooperation, Lehman was faced with about three months of lobbying to obtain the endorsements of the state's medical and osteopathic societies, the center owners, and the various governmental departments that would be enforcing the new law. He saw that representatives of both the medical community and the test centers were present at all meetings. The bill passed the House, 103-1, and the Senate, 40-0. It was signed into law last May 19, with its licensing requirements becoming effective Jan. 1 of this year.

"A bill such as this one requires a tremendous amount of work," says Lehman. Florida legislators meet 60 days a year, starting the first Tuesday in April. From September through March, they hold committee and subcommittee meetings in Tallahassee three or four days a month to prepare measures for the coming

session. "I'm in my Hollywood medical office four mornings a week the rest of the time," Lehman says. "My afternoons are devoted to whatever political work I have to do, and there are often speeches to be made in the evenings. For this, the Legislature pays me $12,000 a year — so you'd better believe it's a job I do because I consider it worth doing." A fellow internist sets aside one day a week to see Lehman's patients — particularly his cardiac cases — when Lehman is on legislative duty.

And CSHB371? "It's a very good law," William Zibell says now. But even before its enforcement gets seriously under way, there seems room to wonder whether it may be regulating yesterday's multiphasic centers, not tomorrow's. The test centers suffered from the adverse publicity that preceded the bill's passage, Zibell claims, and "many are withering away."

Zibell's own Hollywood firm no longer considers itself a test center. "We felt it was wise to remove ourselves from the industry," he says. Shortly after CSHB371's passage, he converted the test center into the Community Medical Clinic, which actively advertises its acceptance of Medicare assignments. "We have 13 physicians who provide primary health care to senior citizens at no charge except for the Medicare deductible," Zibell says. "We're exceptionally busy — we were seeing 600 to 700 patients a week after about the eighth week, and we're still seeing them at that rate."

Zibell recently opened a second clinic — this one in Naples, Fla. — which he says averaged about 150 patients a week in its first few weeks of operation. And he's planning the midsummer opening of a third. That one is to be in St. Thomas, the Virgin Islands, where Zibell says, "practically everybody is eligible for either Medicare or Medicaid."

Segments of the Florida medical community are watching the growth of Zibell's clinics warily. They wonder — perhaps with good reason — whether another confrontation of the CSHB371 type is shaping up.

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Smoking as Self Destruction

Donald G. Nikolaus, M.D.

Smoking is probably the biggest health care problem in the country today. This one health factor is responsible for more expense, both in terms of money and in pain and suffering, than any other. The concern is not just lung cancer but the other problems associated with smoking — addiction, bronchitis, other forms of cancer, emphysema, and heart, stroke and circulation problems.

First, I must mention cancer of the lung. Ninety percent of estimated 80,000 lung cancer deaths in 1977 can be blamed on smoking. *80,000.* That is 1.5 times the number of deaths expected in the U.S. from auto accidents. *80,000.* That is almost double the number of men killed in the Vietnam war, and this will happen in only one year.

The problem with cancer of the lung is it is difficult to diagnose early. It frequently has spread before it is large enough in the lung to cause symptoms. Symptoms are subtle and usually missed. The smoker usually has a cough. Sometimes some blood in the phlegm will be found, but if so, it is usually a late finding. Some patients have symptoms of distant spread, and the lesion in the lung is still too small to show up on x-ray.

This is why the five-year survival of all patients with cancer of the lung treated in the most appropriate manner is only about 7%. In one series, one-half of all lung cancer patients, even with treatment, had died within one month.

Since the treatment of lung cancer is so bleak, the only hope in improving the statistics is one of prevention rather than changes in treatment. Lung cancer traditionally was felt to be a disease of males, but with

women's lib and the increase in female smoking, it has now become a disease of females, as well as males. A recent report from Connecticut actually showed more cancer of the lung in females than males in the past year. This is the first time such a finding has been reported.

Back to the other problems. First is addiction. The smoker is a true addict. The difference between a habit and an addiction is physiologic. If a person stops or changes a habit, he experiences no physiologic changes. When the addict tries to stop, he experiences symptoms. These may be mild, such as nervousness, tremor, increased tension, change in pulse or blood pressure, nausea, etc.

It is very difficult to stop smoking. Personally, I feel it takes a strong motivating experience to stop. Experiencing a major illness or having this happen to a close friend or relative is frequently the incentive to stop. Once stopped, the reformed smoker may still have to fight the continued craving to light up. This may continue for years.

Bronchitis — this is usually a chronic bronchitis. Just as getting smoke in your eyes is irritating, smoke does the same to the mucous membrane or lining of the lung. Continued or repeated irritation causes chronic inflammation. The body tries to protect itself by increasing secretions. These secretions carry the tar and particulate matter from the smoke. The increased secretions cause the cough. So called smoker's cough is really a symptom of chronic bronchitis. This is not actually an infection but the result of chronic exposure to an irritant.

In addition to cancer of the lung, smoking has been associated with other cancers. These include cancer of the lip, tongue, mouth, larynx or voice box, esophagus, stomach and urinary bladder. In all of these cancers the incidence is higher in the smoker than the non-smoker.

Emphysema — Emphysema goes hand-in-hand with chronic bronchitis. Emphysema is actually the natural wearing out process of the lung. We all have a certain amount of emphysema. It is the loss of elasticity in the small air sacs in the lung. It is like repeatedly blowing up a balloon, and after a time the balloon stays overstretched. In emphysema the small air sac stays partially filled with air. When you exhale, you cannot completely get rid of the air in the lungs. This trapped air takes up some of the space so you cannot take as deep a breath as normal. It causes a decrease in your reserve lung capacity. When bad enough, it will cause shortness of breath, wheezing, and some increased secretions. This, again, causes further coughing which aggravates the situation. This is a very debilitating and long lasting problem.

Heart, Stroke and Circulation Problems — These are related to arteriosclerotic changes, sometimes called hardening of the arteries. These problems are much more common and at an earlier age in smokers. These include heart attacks, stroke with paralysis and inability to speak, problems with gangrene of the toes and feet resulting in amputation. True, we are helping a lot of these patients with bypass grafts but at what expense. *Coronary Bypass Surgery* — A few years ago this surgical procedure was developed. Today, five to six years later, between 60,000 and 70,000 of these procedures will be done this year, at an expense of $12,000 to $15,000 each — over $1 billion for this one new surgical procedure.

We no longer can afford to continue crisis and corrective medicine. We must use preventive medicine. What am I suggesting? It is difficult to stop smoking. It is much better to have never started. The Cancer Society has a Target-Five Program to try to decrease smoking by 50% over a five-year period.

Personally, I am tired of beating my head against the wall trying to get people to stop smoking. I would like to see a change in the label on the tobacco package. I would suggest this not necessarily to get the smoker to stop smoking. I feel that it might help us convince our youths they should never start. The labels should read "THIS PRODUCT MAY CAUSE ADDICTION, BRONCHITIS, CANCER, EMPHYSEMA, HEART, STROKE AND CIRCULATION PROBLEMS."

Reprinted from ACCESS Magazine, April/May, 1978.

He that cannot forgive others breaks the bridge over which he must pass himself, for every man has need to be forgiven.

George Herbert

Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Side Effects by Mel and Karen Silverstein. 264 pages. Price $7.95. Doubleday and Company, Inc., Garden City, N.Y., 1978.

Side Effects is a novel which incorporates information about breast cancer into the plot of a love affair between a handsome surgeon and an improbably beautiful, independently wealthy young woman. Paragraphs dealing with the physical and emotional aspects of breast cancer are inserted between rather explicit love scenes, emotional outbursts replete with four letter words and descriptions ad nauseum of Cynthia's gorgeous, well-endowed body and Dr. Jon Meyer's virility.

To whom is this book addressed? It is not leisure time reading since there is much better writing in other novels without the information about cancer tucked in. Much of that is available from sources like the Cancer Society and physicians' offices. The preoperative patient would probably not want to read about and anticipate the problems brought out in the story. I would certainly have been twice as apprehensive if I had read **Side Effects** before having undergone my mastectomy. At that point a woman needs good, solid information, not details of the possible sexual and emotional hangups she may later experience. The majority of postmastectomy patients have little in common with the single, gorgeous Cynthia, her lover, Jon, or her free-swinging life at the Club. Most of us have a home and family to once again assume responsibility for and any emotional problems that may arise after the operation have to be taken care of in that context. The story was very unrealistic.

One of the best books I have read is still **First You Cry** by Betty Rollin, which was reviewed in an earlier issue of JFMA. This was the true story of a woman who underwent a mastectomy, written with intelligence and wit.

Suzanne Cohan
Pensacola

Mrs. Cohan is the wife of Robert Cohan, M.D., a Pensacola pediatrician-allergist. They have two children and Mrs. Cohan teaches high school English.

Clinical Cardiology by Maurice Sokolow, M.D. and Malcolm B. McIlroy, M.D. 659 pages. Price $16.00. Lange Medical Publications, Los Altos, California. 1977.

The purpose of Clinical Cardiology, "to provide medical students, house staff, trainees in cardiology, and other physicians in practice with a balanced, integrated up-to-date account of the important aspects of adult cardiovascular diseases and the physiologic bases of their treatment," is admirably fulfilled.

However, there are some minor criticisms to be stated. The title should have noted that this commendable work is in reality a primer and introduction to clinical cardiology. No one volume of 659 pages could adequately cover the field of cardiology today. Friedberg's 1,081 pages and Hurst and Logue's 1,495 pages also would require collateral reading for a Fellow in Cardiology.

The Functional and Therapeutic Classification of Heart Disease which has been so useful for so many years is covered, but no mention is made of the classification of "Cardiac Status and Prognosis" introduced in 1973 by the New York Heart Association as being a more useful tool.

The format and manner of presentation is most useful and the illustrations and diagramatic formulations are informative. The organization of the discussion beginning with "Physiology of the Circulatory System" is notable. This first chapter is presented in a lucid and useful manner. "History Taking" gives some practical pointers as well, as does the chapter on "Physical Examination."

"Clinical Physiology" affords a succinct and sound basis for clinical application of laboratory knowledge. "Special Investigations: Non-Invasive" follows with an opportunity for basic correlations with clinical physiology. "Special Investigations: Invasive" provides an insight into these useful modern methods.

The chapters on Therapeutic Procedures and the individual disease states are well-balanced; however, few of the more recently introduced drugs such as norpace are not mentioned.

The chapters on conduction defects and cardiac arrhythmias are current. The miscellaneous closing

subjects are covered adequately: Cardiac Tumors, Miscellaneous Forms of Heart Disease, Heart Disease in Pregnancy, Cardiac Disease and the Surgical Patient.

Sokolow and McIlroy are to be commended on this useful, fairly-priced volume which fulfills well the goals they set for themselves. We look forward to the planned revised editions at two year intervals.

Samuel Epstein, M.D.
Palm Beach

Dr. Epstein is in the private practice of Internal Medicine in Palm Beach, Florida.

The Family Crucible by August Y. Napier, Ph.D. with Carl A. Whitaker, M.D. 301 Pages. Price $11.95. Harper & Row Publishers, New York, 1977.

Written presumably for the layman, this book presents the author's views of family therapy. He uses for examples the case of a family group who entered therapy to work out several crises. As is frequently the situation, the "problem" of misbehavior of a college age daughter was the presenting symptom of a deeper marital problem. In novelistic style, the sessions unfold more or less dramatically. At other times, when the author is giving background material about family therapy, problems and solutions, it drags like a business report.

My interest in the book is two-fold. First, Dr. Whitaker was the chairman of the department of psychiatry during my medical school days at Emory. He was somewhat of a hero to many of the students. Second, in common with other physicians, I'm interested in helping people improve and will take help any way it can be obtained.

It could be argued that there are too few qualified family therapists and that the cost of therapy is prohibitive for all but the affluent, but these objections fit most therapies.

This book may be of interest to both laymen and professionals seeking information on family therapy presented in an informal way.

F.N.V.

Vote For
Constitutional Amendment #1
Separate Department of Health

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Annual Review of Neuroscience with 28 contributing authors. 506 Pages. Illustrated. Price $17.00. Annual Reviews, Inc., Palo Alto, California, 1978.

Pharmacological and Toxicological Perspectives of Commonly Abused Drugs by Darryl Inaba, Ph.D., E. Leong Way, Ph.D., Kenneth Blum, Ph.D. and Sidney H. Schnoll, M.D. 44 Pages. National Drug Abuse Center, Rosslyn, Virginia, 1978.

Review of Medical Microbiology, 13th Edition by Ernest Jawetz, M.D., Joseph L. Melnick, Ph.D. and Edward A. Adelberg, Ph.D. 550 Pages. Illustrated. Price $12.00. Lange Medical Publications, Los Altos, California, 1978.

Currents in Alcoholism, Biological, Biochemical, and Clinical Studies, Edited by Frank A. Seixas, M.D. 601 Pages. Illustrated. Price $31.50. Grune & Stratton, Inc., New York, 1978.

Controlling the Use of Therapeutic Drugs: An International Comparison edited by William M. Wardell. 263 Pages. American Enterprise Institute for Public Policy Research, 1978.

Visionetics, The Holistic Way to Better Eyesight by Lisette Scholl with John Selby. 222 Pages. Illustrated. Price $4.95. Doubleday & Company, Inc., New York, 1978.

Directory of Pathology, Training Programs, 1979-80 by the Intersociety Committee on Pathology Information, Inc. 470 Pages. Illustrated. Price $25.00. Geo. W. King, Co., Baltimore, 1978.

Measuring Medical Education, The Tests and the Experience of the National Board of Medical Examiners, Second Edition, by John P. Hubbard, M.D. 187 Pages. Illustrated. Price $12.00. Lea & Febiger, Philadelphia, 1978.

Basic and Clinical Immunology, 2nd Edition by H. Hugh Fudenberg, M.D., Daniel P. Ftites, M.D., Joseph L. Caldwell, M.D. and J. Vivian Wells, M.D. 758 Pages. Illustrated. Price $14.50. Lange Medical Publications, Los Altos, California, 1978.

Sniff, Sniff, Al-er-gee by Claude A. Frazier, M.D. and illustrated by Paul H. Carlson. 36 Pages. Price $5.65 (hardcover) $2.65 (paperback). Johnny Reads, Inc., St. Petersburg, 1978.

General Urology, 9th Edition, by Donald R. Smith, M.D. 541 Pages. Illustrated. Price $14.50. Lange Medical Publications, Los Altos, California, 1978.

Review of Medical Pharmacology, 6th Edition, by Frederick H. Meyers, M.D., Ernest Jawetz, M.D. and Alan Goldfien, M.D. 762 Pages. Illustrated. Price $14.50. Lange Medical Publications, Los Altos, California, 1978.

The Metabolic Management of the Critically Ill by Douglas W. Wilmore, M.D. 262 Pages. Price $22.50. Plenum Publishing Corporation, New York, N.Y., 1978.

MEETINGS

Approved by the FMA Committee on Continuing Medical Education

NOVEMBER

Thromboembolism and Thrombolytic Therapy, How-When-and Why, Nov. 2, Mount Sinai Medical Center, Miami Beach. For information: CME Office, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, Florida 33140.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Nov. 6-11, Jackson Memorial Hospital, Miami.*

Interdisciplinary Seminar, Nov. 7-10, Cedars of Lebanon Health Care Center, Miami. For information: Thelma MacGregor, 1400 Northwest 12th Ave., Miami 33136.

Medicine in Maturity (Geriatric Medicine), Nov. 8-12, Don CeSar Hotel, St. Petersburg Beach. For information: American Medical Women's Association, 1740 Broadway, New York, New York 10019.

Management of Peptic Diseases — Cimetidine and Therapeutic Alternatives, Nov. 9, University of South Florida Medical Center, Tampa.+

Interim Meeting, Florida Society of Otolaryngology, Nov. 10-12, Bay Hill Colony Resort, Orlando. For information: J. James Rooks Jr., M.D., 1204 Northwest 69th Terr., Gainesville 32601.

Current Topics in Perinatology, Nov. 11-18, Caribbean Cruise.*

Adolescent Medicine, Nov. 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Clinical Family Planning for Physicians, Nov. 13-14, University Hospital, Jacksonville. For information: James A. O'Donnell, M.D., 655 West 8th Street, Jacksonville 32209.

Laparoscopy Course, Nov. 13-14, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Medical Aspects of Aging, Nov. 17-18, Gainesville Hilton, Gainesville.**

Fracture Bracing, Nov. 17-19, location to be announced.*

Florida Endocrine Society's Fall Meeting, Nov. 18-19, The Colony Beach & Tennis Resort, Sarasota. For information: Yank D. Coble Jr., M.D., 2700 Riverside Avenue, Jacksonville 32205.

Diagnosing and Treating Anxiety and Depression, Nov. 21, Holy Cross Hospital, Fort Lauderdale. For information: Jon R. Fichtelman, M.D., P.O. Box 23460, Fort Lauderdale 33307.

***For information: Contact Division of Continuing Medical Education, D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

DECEMBER

7th Annual Refresher Course for Nurse Anesthetists, Dec. 1-3, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

8th Family Practice Review, Dec. 4-8, Candada Beach/LaConcha Convention Center, San Juan, P.R. For information: Bill Rockwood, Gainesville.**

Echocardiography In-Service Workshop, Dec. 4-8, Jackson Memorial Hospital, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Dec. 4-9, Jackson Memorial Hospital, Miami.*

Neuro-Ophthalmology, Dec. 6-9, Key Biscayne Hotel, Miami.*

Glaucoma Symposium, Dec. 7-9, University of South Florida Medical Center, Tampa. For information: W. E. Layden, M.D., P.O. Box 21, MDC, University of South Florida, Tampa 33612.

Orthotics and Prosthetics, Dec. 7-10, Americana Hotel, Miami Beach.*

Hand Surgery, Dec. 8-9, Americana Hotel, Miami Beach.*

Cardiac Symptoms and Arrhythmias — The Diagnosis and Treatment, Dec. 8-10, Americana of Bal Harbour, Miami. For information: IMEC, 64 Inverness Drive East, Englewood, Colorado 80110.

Coronary Disease, Exercise Testing, and Cardiac Rehabilitation, Dec. 8-10, Konover Hotel, Miami. For information: IMEC, 64 Inverness Drive East, Englewood, Colorado 80110.

Vaginal Surgery Seminar, Dec. 10-16, Royal Biscayne Hotel & Racquet Club, Miami.*

Laparoscopy Course, Dec. 11-12, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

High Density Lipoprotein: Results of the Framingham Study, Dec. 14, Manatee Memorial Hospital, Bradenton. For information: Allen R. Sklerov, M.D., 4804 26th St., West, Bradenton 33507.

1979

JANUARY

The 6th Annual Symposium in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Jan. 3-6, Miami.*

2nd Annual Oral Pathology Review, Jan. 8-12, Jackson Memorial Hospital, Miami.*

Art and Science in Therapy of Difficult Problems in Surgery, Jan. 10-13, Americana Hotel, Miami Beach.*

Postgraduate Seminar in Pediatric and Adult Urology, Jan. 10-13, Carillon Hotel, Miami Beach. For information: Victor Politano, M.D., 6614 Miami Lakes Drive, East Miami Lakes 33014 or phone (305) 822-6000.

The Biology & Psychopharmacology of Depression, Jan. 13-14, Innisbrook Golf & Country Club, Tarpon Springs. For information: Howard L. Masco, M.D., 1801 South Boulevard, New Port Richey 33552.

Annual Seminar in Otolaryngology, Jan. 15-18, Doral Country Club and Hotel, Miami Beach.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Jan. 15-20, Jackson Memorial Hospital, Miami.*

Miami Winter Symposia, Jan. 22-28, Intercontinental Hotel, Miami.*

4th Annual Review and Recent Practical Advances in Pathology, Jan. 23-26, Konover Hotel.*

Psycho-Social Aspects of Cleft Palate, Jan. 26-27, Lake Buena Vista. For information: Frances S. Smith, M.D., 1736 University Blvd., S., Jacksonville 32216.

Winter Conference on Principles of Practice Management, Jan. 27-Feb. 3, Lion Square Lodge, Vail, Colorado.*

Vail Conference in Intensive Care, Jan. 27-Feb. 3, The Mark Resort, Vail, Colorado.*

Laparoscopy Course, Jan. 29-30, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

A Neurological Update 1979, Jan. 29-Feb. 3, Konover Hotel, Miami.*

FEBRUARY

24th Central Florida Medical Meeting, Feb. 1-4, Contemporary Resort Hotel, Lake Buena Vista, Florida. For information: Sam F. Elder, M.D., 601 Rollins Avenue, Orlando 32803.

Second Symposium on Neurological Surgery of the Ear, Feb. 3-8, Sarasota. For information: Ms. Susan G. Brown, 1845 Hillview Street, Sarasota 33579.

Fifth Annual Vail Conference in Anesthesiology, Feb. 3-10, The Mark Resort, Vail, Colorado.*

Obstetrical and Gynecological Ultrasound In-Service Workshop, Feb. 5-9, Jackson Memorial Hospital, Miami.*

Florida Midwinter Seminar in Ophthalmology and Otolaryngology, Feb. 5-10, Americana Hotel, Miami Beach.*

Imageology 1979, Feb. 16-23, Konover Hotel, Miami Beach. For information: Mrs. Lucy E. Kelley, c/o Medical Seminars, P.O. Box 343762, Coral Gables 33134.

6th Annual Pediatric Dermatology Seminar, Feb. 17-25, M/V Buccaneer, Galapagos Islands. For information: Guinter Kahn, M.D., 16800 Northwest 2nd Avenue, Suite 401, North Miami Beach, Florida 33169.

Pediatric Dermatology Seminar, Feb. 17-26, M/S Buccaneer, Galapagos Islands, South America. For information: Guinter Kahn, M.D., 16800 Northwest 2nd Ave., Suite 401, North Miami Beach 33169.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Feb. 19-24, Jackson Memorial Hospital, Miami.*

Management of the Tiny Baby — 1979, Feb. 22-23, Dutch Inn, Lake Buena Vista. For information: Keith S. Kanarek, M.D., 1416 South Orange Avenue, Orlando, Florida 32806.

OB-GYN Cruise Seminar, Feb. 24-Mar. 6. (Cruise line to be announced).*

12th Pan American Congress of Ophthalmology, Feb. 25-Mar. 2, Fontainebleau Hotel, Miami Beach.*

Laparoscopy Course, Feb. 26-27, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Basic Neurology for Psychiatrists, Family Practitioners and General Practitioners, Feb. 26-Mar. 2, Konover Hotel, Miami.*

Teaching Conference in Clinical Cardiology, Feb. 28-Mar. 3, Americana Hotel, Miami Beach.*

Eleventh Teaching Conference in Clinical Cardiology, Feb. 28Mar. 3, Americana Hotel, Bal Harbour.*

MARCH

Gynecologic Endocrinology and Infertility, Mar. 1-3, Orlando Hyatt House, Orlando. For information: Bernard Cantor, M.D., Gainesville.**

Medical Imaging 1979, Mar. 8-10, Royal Biscayne Hotel, Miami.*

Medical Hypnosis and Short-Term Psychotherapy, Mar. 10-14, Americana Hotel, Miami Beach.*

Current Trends in Radioimmunoassay 1979, Mar. 11-13, Royal Biscayne Hotel, Miami.*

American and European Views on Anesthesiology, Mar. 24-31, Zermatt, Switzerland.*

Laparoscopy Course, Mar. 26-27, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

APRIL

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 9-14, Jackson Memorial Hospital, Miami.*

Laparoscopy Course, Apr. 23-24, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Sarasota Medical Awards Conference, Apr. 26-29, Hyatt House, Sarasota. For information: S. P. Bralow, M.D., 1515 South Osprey Ave., Sarasota 33579.

Seventh Annual Surgical Intensive Care Symposium, Apr. 27-30 (location to be announced).*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 30-May 5, Jackson Memorial Hospital, Miami.*

MAY

7th Annual Intensive Care Symposium, May 4-7, Eden Roc Hotel, Miami Beach.*

Ultrasound (General) In-Service Workshop, May 7-11, Jackson Memorial Hospital, Miami.**

Laparoscopy Course, May 28-29, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

JUNE

Master Approach to Cardiovascular Problems — 7th Annual Conference, June 8-10, The Contemporary Hotel, Lake Buena Vista.*

Laparoscopy Course, June 25-26, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONERS

GENERAL PRACTITIONER: For well equipped medical clinic immediately adjacent to 120 bed skilled nursing facility; would also act as medical director for nursing home. Salary 100% of intake. Contact: Administrator, Wakulla Manor Nursing Home, P.O. Box 508, Crawfordville, Florida 32327. Phone: (904) 926-7181.

GENERAL PRACTITIONER OR INTERNIST: Excellent opportunity, assume long established practice with a multispecialty group. Present associate leaving the area. Florida license required. Please submit curriculum vitae to John F. Kerwick, Hollywood Clinics, P.A., Box 2308, Hollywood, Florida 33022. Phone: (305) 923-4646.

FAMILY PRACTITIONER, board certified, to join 20 man multispecialty group. Please submit curriculum vitae to F. Linn Wagner, M.D. Chief of Staff, Suncoast Medical Clinic, 700-6th Street South, St. Petersburg 33701.

WANTED: Physician generalist as a County Health Department Physician II to carry out primary care services 40 hours per week. Benefits of sick and annual leave, hospitalization, life insurance and retirement. Call S. D. Rowley, M.D., Director, Duval County Health Department (904) 633-2280.

WANTED: GENERAL PRACTITIONER, excellent opportunity to associate with a completely equipped medical clinic in highly populated middle income (or high rise apartments) residential neighborhood in Miami area. Kindly send curriculum vitae to C-892, P.O. Box 2411, Jacksonville, Florida 32203.

FLORIDA: PRIMARY CARE (FAMILY PRACTICE, INTERNAL MEDICINE). Associate with 62-year old board certified family practitioner. Salary, partnership possibility and eventual ownership in future. U.S. graduate preferred. R. M. Thompson, M.D., 6215 South Dixie Highway, West Palm Beach, Florida 33405. Phone: (305) 582-7451.

FAMILY PRACTITIONER. Growing community in northeast Florida offers immediate opportunity to establish private practice. Excellent schools, beautiful beaches, year-round outdoor recreation. Contact: Claude Weeks, Executive Director, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

SPECIALISTS

HEMATOLOGIST-ONCOLOGIST for town in Southwest Florida. Write C-885, P.O. Box 2411, Jacksonville, Florida 32203.

BOARD CERTIFIED GENERAL SURGEON — Excellent opportunity for surgeon, preferably with Thoracic or Vascular surgery experience, to practice in expanding North Florida Community. Attractive 128-bed new hospital which provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

EXCELLENT OPPORTUNITY for Board Certified Urologist; needed for fast growing town in coastal southwest Florida. Write C-885, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST — Excellent opportunity for physician to practice internal medicine in expanding North Florida community. No internist currently practicing in community. Attractive 128-bed new hospital which provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

TWO BOARD CERTIFIED INTERNISTS actively seeking third associate in busy clinical practice. Internal medicine with or without subspecialty training, southeast Florida coast. Contact Yale Citrin, M.D. or Peter S. Irving, M.D., 3435 Johnson Street, Hollywood, Florida 33021.

CENTRAL FLORIDA MULTISPECIALTY CLINIC HAS OPENING for second general surgeon. Good financial opportunity; new well equipped office near three hospitals. Write C-893, P.O. Box 2411, Jacksonville, Florida 32203.

ASSOCIATE IN RADIOLOGY NEEDED. Established private practice in metropolitan New Jersey. Knowledge of Spanish helpful. Write C-894, P.O. Box 2411, Jacksonville, Florida 32203.

SEEKING PHYSICIANS TO RELOCATE TO MARIANNA, FLORIDA, trade area of 40,000 people. Professional study and medical staff supports the recruitment of an OB-GYN, Urologist, Orthopedist, Internal Medicine and Emergency Room physicians to supplement the 12 already here. New 90-bed hospital now under construction. Ideal small town living conditions. Financial and business assistance available to qualified physicians. Phone: (904) 526-2200 — Elwin O'Steen.

SURGEON WANTED: Excellent opportunity in growing Northwest Florida Community with a modern 34-bed short term General Hospital. No surgeon available in immediate trade area. Community is located ideally between metropolitan areas. Must be receptive to a moderate amount of general practice and possess a Florida license (or qualify to obtain a Florida license promptly). Send curriculum vitae to: Administrator, 401 E. Byrd Ave., Bonifay, Florida 32425.

EMERGENCY PHYSICIAN with postgraduate training or three years experience for prestigious University General Hospital in Tampa, Florida. 600 beds, 45,000 plus visits per year with brand new 17,000 square feet Emergency Department. Guaranteed income for 44 hours per week with two weeks education leave and two weeks vacation. Malpractice paid. Please send curriculum vitae, three letters of recommendation and direct all inquiries to: Philip J. Fagan Jr., M.D., Medical Director, P.O. Box 9639, Marina del Rey, California 90291. Phone: (213) 822-1312.

EMERGENCY PHYSICIANS for central Florida city to work in industrial clinic and minor emergency center. Malpractice paid. Forty hours per week plus paid vacation. Please direct all inquiries to Robert F. Towne, President, Executive Health Services, Inc., 2033 East Edgewood, Suite #5, Lakeland, Florida 33803. Phone: (813) 687-4524.

MISCELLANEOUS

LAMINAR FLOW OPERATING ROOMS tested for conformation to Federal Standard 209-B, also yearly recertification test performed. Contact Jake Truslow Company, P.O. Box 1359, Melbourne, Florida 32901. Phone: (305) 723-3382.

MEDICAL DIRECTOR for Professional Standards Review Organization. Professional leadership position in an organization involved with quality of care and appropriate utilization activities. Requires an ongoing interface with professional providers of medical care. Must possess a minimum of five years experience in the practice of medicine and should be knowledgeable of techniques of professional review and medical audit. S/HE should be definitely team-oriented. Excellent starting salary plus liberal fringe benefits. Reply with curriculum vitae to Medical Director, Search Committee, Professional Foundation for Health Care, Inc., 709 W. Bay Street, Tampa, Florida 33606. An EO Employer.

Situations Wanted

GENERAL AND VASCULAR SURGEON, 35, university trained, board certified, Florida licensed. Seeks practice opportunity, solo, partnership or group. Available 3 months notice. Write C-837, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST-NEUROLOGIST, 33, university trained in two specialties. Would prefer to practice both Internal Medicine and Neurology in multispecialty group or other community situation. Write to Box 221, Glen Oaks, New York 11004.

POSITION WANTED: YOUNG BOARD CERTIFIED FAMILY PRACTITIONER seeks position in family practice or multispecialty group. Large coastal setting preferred. Contact: Christopher R. Martin, M.D., 1624 McPherson Blvd., Fremont, Ohio 43420. Phone: (419) 332-7610 (evenings).

ANESTHESIOLOGIST, Florida licensed, university trained, post-training fellowship, board eligible, wide experience in all anesthetic modalities. Seeks practice opportunity in Florida. Available immediately. Prefer group or fee-for-service. Other reasonable offers considered. Phone: (516) 938-9469 — evenings.

ANESTHESIOLOGIST, Marquette graduate, 1953; Adriani trained; qualified competent clinician with boards. Special interest and experience in open heart anesthesia. Desire 2-4 week locum tenens with possible permanent association. M. Phillips, M.D., 1531 E. Fairmount Avenue, Milwaukee, Wisconsin 53217.

UROLOGIST, 33, married, American graduate, military completed, Florida licensed, trained at large southeastern university, available October, 1978. Write Robert Karp, M.D., 3021 Panaridge Circle, Birmingham, Alabama 35216 or call (205) 934-3411 #401.

PATHOLOGIST — Certified CP/AP, Florida licensed, native U.S., excellent C.V. and experience as director. Current postgraduate training and certification through 1980. Write P.O. Box 11158, 227 East Ontario Street, Chicago, Ilinois 60611.

CARDIOLOGIST, board certified internal medicine (ABIM), eligible in cardiology, well trained in invasive (sones, yudkins) and noninvasive cardiology, seeks practice (partnership or hospital-based) in large Florida community. Available July 1979. Write: 4014 West 13 Mile Road, Apt. 11, Royal Oak, Michigan 48072.

ORTHOPEDIC SURGEON, 31, board eligible, currently fellow in hand surgery, Florida licensed. Seeks practice opportunity — group or partnership, preferably South-East Florida or Tampa. Available January 1979. Reply: Geoffrey Coll, M.D., 8960 N.W. 8th St., #402, Miami, Florida 33172.

SITUATION WANTED: Young cardiologist trained in invasive and noninvasive cardiology (Cath., Angio, ECHO, Treadmill) desires location in Florida. Solo or Associate. Please reply: C-895, P.O. Box 2411, Jacksonville, Florida 32203.

ORTHOPAEDIST — 35, board eligible, married, university trained, experience includes reconstruction and hand with Florida license. Seeks private practice situation. Write: C-897, P.O. Box 2411, Jacksonville, Florida 32203.

CANADIAN OBSTETRICIAN AND GYNECOLOGIST with senior university and hospital appointment wishes to relocate in Florida. Extensive clinical and academic experience in all aspects of specialty, including high risk pregnancy. Write C-896, P.O. Box 2411, Jacksonville, Florida 32203.

ANESTHESIOLOGIST, Florida licensed, university trained, board eligible with good experience. Seeks practice opportunity in Florida. Has malpractice insurance in Florida. Prefer fee-for-service or other reasonable offers considered. Phone: (904) 567-7711 evenings.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

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The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

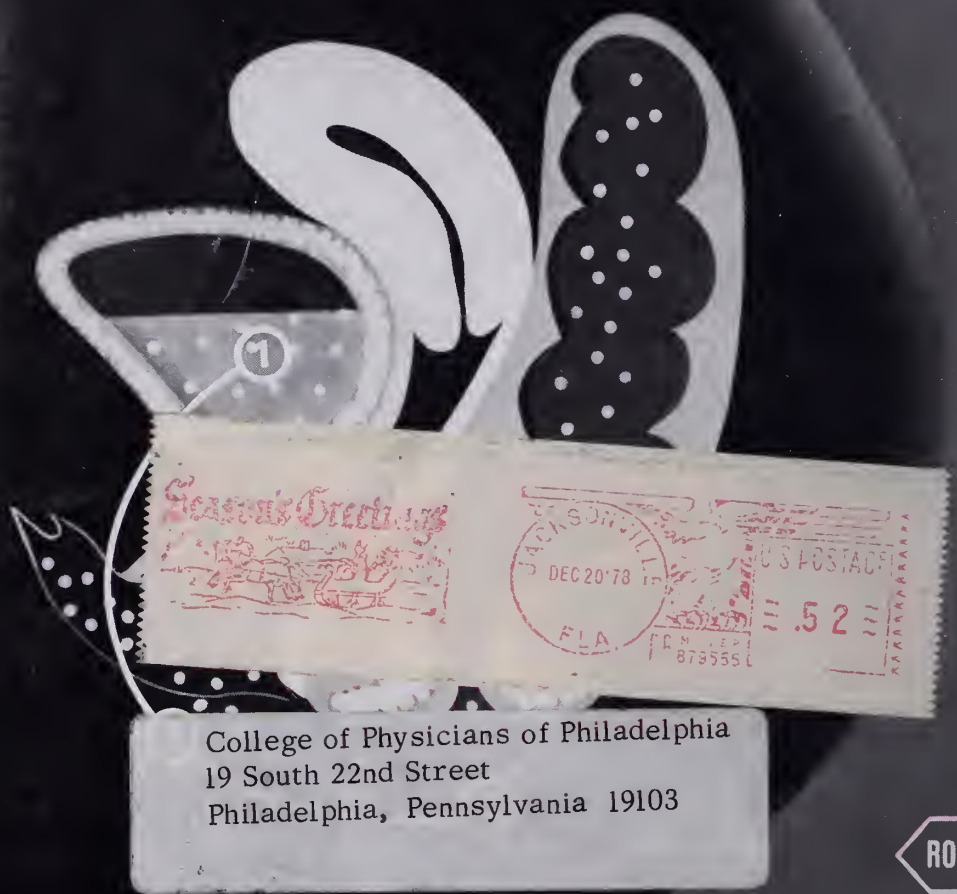
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Please see back cover.

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Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

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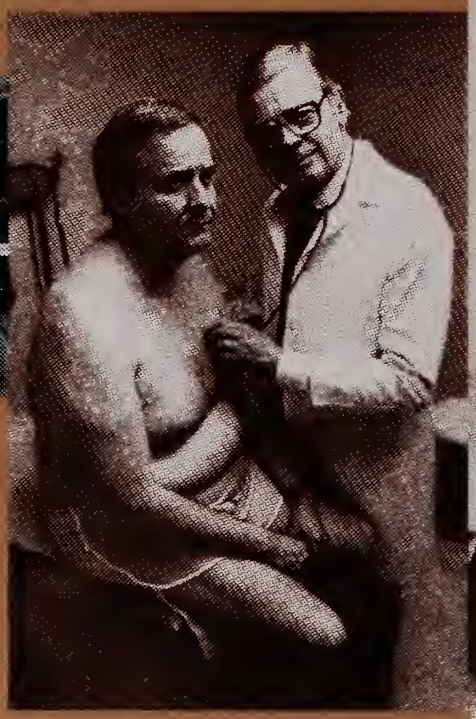
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Please see next page for summary of product information.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema; minor menstrual irregularities; nausea and constipation; extrapyramidal symptoms; increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally; making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults.* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

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NOVEMBER COVER — The concept of the cover was conceived by Mr. Richard J. Snyder, Assistant Editor, after reading the article on page 883 entitled "Hypercalcemic Crisis in Primary Hyperparathyroidism" by George L. Irvin, M.D. and Ishmael J. Torres, M.D., and it was drawn by Mr. Amit Pietra, a medical illustrator in Gainesville.

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*Executive Committee

DONALD C. JONES, Executive Director

Summary of the FMA Board of Governors Meeting October 5-6, 1978

THE BOARD:

1979 Annual Meeting

Approved the format for the 1979 Annual Meeting scheduled to be held May 23-27, 1979 Diplomat Hotel, Hollywood, Florida.

Wednesday, May 23 —
10:00 a.m. — General and Delegates Registration
1:00-4:15 p.m. — Scientific Sections
4:30-5:30 p.m. — First House of Delegates

Thursday, May 24 —
8:00 a.m. — Blue Shield Annual Meeting
9:30 a.m. — Reference Committee I & V
10:00 a.m. — Reference Committee II & IV
10:30 a.m. — Reference Committee III
12:15-1:30 p.m. — Auxiliary and FLAMPAC Luncheon
1:30-5:30 p.m. — Scientific Sections
Reference Committees, if necessary
8:30-4:30 p.m. — VISIT EXHIBITS

Friday, May 25 —
8:00-10:45 a.m. — Scientific Sections and Specialty Groups
11:00 a.m. — General Session (Baldwin Lecture)
1:30-5:30 p.m. — Scientific Sections
6:30-7:30 p.m. — President's Reception
8:30-4:30 p.m. — VISIT EXHIBITS

Saturday, May 26 —
8:00-12:00 noon — Specialty Groups and Scientific Sections
8:30-4:30 p.m. — VISIT EXHIBITS
1:00-2:45 p.m. — Specialty Groups and Scientific Sections
3:00 p.m. — Second House of Delegates
Specialty Group Socials

Sunday, May 27 —
9:00 a.m. — Third House of Delegates
Post Convention Board of Governors

Scientific Theme: Nutrition

The theme for the 1979 Annual Meeting will be Nutrition and will include several noted speakers in that field. Nutritional topics will include the art of nutritional diagnosis, clinical nutritional problems, aging and nutrition, alcohol and nutrition, diabetes and nutrition. Also, each specialty group has been requested to include a paper on Nutrition in their scientific sections.

Information regarding scientific sections to be presented at the annual meeting **will be included in the November issue of the FMA Journal.**

Guest Speakers

Noted columnist, James Kilpatrick will present the Abel S. Baldwin lecture as the President's guest speaker on Friday, May 25, 1979. The Annual Auxiliary/Flampac Luncheon will be held on Thursday, May 24, 1979 (change from previous years). The keynote speaker will be announced in the near future.

1979 FMA Leadership Conference

Directed that the FMA hold a Leadership Conference for county medical societies to be held January 27-28, 1979, at the Orlando Hyatt House.

National Health Insurance

Adopted the following statement of policy regarding National Health Insurance:

It is a well recognized fact that Americans have the best medical care and delivery system in the world today, and most polls indicate the public is generally satisfied with both the quality and quantity of medical services. Moreover, the polls have consistently reflected that the American people hold their individual physician in higher regard and trust than any other professional. It is this very personal doctor-patient relationship that will be dismantled and ultimately destroyed by National Health Insurance.

The primary thrust for a nationalized, socialized system of medical care has continuously come from the political arena where logic is often lacking.

At this time, it would be unwise for organized medicine, at any level to sponsor or support federal legislation to further nationalize or socialize physicians' services in this country.

There is a need to improve our present system — not by discarding or dis-

regarding our present one — and we recommend the following modifications:

1. Requiring minimum standards of adequate benefits in all health insurance policies sold in the United States with appropriate deductible and co-insurance.
2. A simple system of uniform benefits provided by the federal, state, and local governments for those individuals who are unfortunate enough through no fault of their own, i.e., age, disability, financial hardship, etc.) not to be able to provide for their own medical care.
3. A nationwide program by the private insurance industry of America (and government if necessary for re-insurance) to make available catastrophic insurance coverage for those illnesses and individuals where the economic impact of a catastrophic illness could be tragic. All catastrophic coverage should have an appropriate deductible and co-insurance to make it economically feasible and to avoid abuse.

Standardized Health Claim Form

Received a report that the Insurance Commissioner at the request of the FMA has agreed to hold a public hearing on October 23, 1978 in Tallahassee regarding the utilization of a standardized health claim form for physicians' services. Legislation passed during 1977 legislature mandated the Insurance Department to implement a standardized claim form to be accepted by all third parties and the Department of HRS. FMA will present testimony at the public hearing in support of allowing attachments provided the attachment contains all the necessary information required on the standardized form. Implementation of the law will be delayed pending the outcome of the public hearing.

AMA Dues Collection Reimbursement

Authorized sharing with county medical societies reimbursements received from the AMA for collection of AMA dues on a 50% pro rata basis.

CME Reporting Form

Recommended to the House of Delegates that the criteria for the FMA Continuing Medical Education Program be amended to provide for the mailing of CME Reporting Forms as indicated with appropriate advance notice and further that any legislation regarding mandatory CME requirements include criteria comparable with the FMA CME requirements.

AMA Proposed Resolution on Cost Containment

Adopted the AMA proposed resolution on the cost of medical care:

Resolved, that the FMA continue to encourage its member physicians to help moderate increases in medical care costs by using appropriate restraints to keep fee increases more nearly in line with the annual increase in cost of living; and be it further

Resolved, that the FMA endorse the voluntary effort as a responsible private-sector activity to restrain increases in hospital costs without arbitrary limits or government intervention.

Uniform Fee Schedule

Received a report regarding establishment of a task force by the State Department of Administration to develop a uniform fee schedule, for each provider class, for all medical service programs administered by the Department of HRS. The task force, mandated by the 1977 legislature, is charged with developing a uniform level of reimbursement for physicians' services. FMA has designated physicians to serve in an advisory capacity to the task force.

Constitution Revision #1

Noted with commendation and appreciation the efforts of Dr. Ed Annis as a member of Florida's 1977 Constitution Revision Committee including his efforts to bring about re-establishment of a Separate Department of Health which is included in Revision #1.

Received a report from the President regarding the FMA conference on Revision #1 held September 23, 1978 and the support expressed by FMA's component societies and allied organizations for gaining approval of Revision #1 on November 7, 1978 in the general election.

PMUR Procedures

Directed that the procedures currently being followed for conducting Peer Medical Utilization Review by the Florida Medical Foundation through its contract with Blue Shield of Florida be revised to insure that the Peer Review process is being carried out in the most appropriate manner including adequate safeguards for the protection of an individual physician undergoing the voluntary PMUR process with strict administration of this process by his peers.

COUNCILS AND COMMITTEES

Allied Professions

Amphatamines and Methaqualone

Recommended that the State Board of Medical Examiners consider adoption of rules regarding approved uses of amphetamines and Methaqualone in Florida.

Florida Occupational Therapy Association

Extended formal recognition as an Allied Profession to the Florida Occupational Therapy Association.

Committee on County Medical Societies

Standardized Membership Application

Approved in principle a standardized FMA Data for Archives form and county medical society application subject to review of the proposed standardized application by county medical societies with final recommendations to be submitted to the House of Delegates in 1980.

AMA Membership Recruitment

Approved inclusion of a message promoting AMA membership with the dues statements prepared for county medical societies.

Council on Scientific Activities

Medical Students

Noted the high degree of success achieved in involvement of student editors in the FMA Journal and authorized appointment of student FMA members to other Committees of the Association.

FMA Journal Editor

Commended FMA Journal Editor, Gerold L. Schiebler, M.D. and the staff of the FMA Journal for continued excellence and particularly for the Florida Magazine Association Special Issue Award and involvement of students in editorial capacities.

Executive Editor of the Journal

Congratulated Mr. Edward Hagan, Executive Editor of the FMA Journal upon his election as President of the Florida Magazine Assocition.

1978 Annual Meeting

Commended Dr. Henry Yonge and Dr. Maurice Laszlo for their outstanding work on the 1978 Annual Meeting Scientific Program.

Special Committee on Blue Shield

Received as information a progress report on the deliberations of the Special Committee on Blue Shield, established at the direction of the House of Delegates in May, 1978 for the purpose of investigating and reporting to the House of Delegates the implications of Blue Shield withdrawing from all federal contracts and of FMA withdrawing sponsorship of Blue Shield. The Committee will hold additional meetings prior to its report being submitted to the House of Delegates to insure objective evaluation of all factors in determining the long range effect of the maintenance or alteration of FMA's relationship with Blue Shield.

Ad Hoc Committee on State Board of Medical Examiners

Investigative and Legal Assistance

Encouraged the State Board of Medical Examiners to utilize the most effective management tools available in determining its work load and personnel requirements including seeking additional investigative and attorney positions including upgrading classifications of investigators. Expressed support for SBME in accomplishing these objectives in the legislature.

Investigative Procedures

Took the position that the State Board of Medical Examiners should be thorough and aggressive in its pro sectorial function and that all available witnesses who have relevant information to the issues be utilized as necessary in determining whether or not an individual physician has violated the Medical Practice Act.

Legislation

Adopted the following positions regarding legislation effecting the SBME:

- Opposed any legislation that would bifurcate the SBME into disciplinary Board and licensing Board.
- Supported clarifying legislation in the Medical Practice Act that would define professional misconduct relative to kickbacks and rebates.

Physician Trained Assistants

Supported legislation if necessary to clarify the so-called "Bond Clinic Situation" so that there is no legal question regarding the ability of a trained medical assistant to perform any medical function so long as it is under control of a physician.

Council on Legislation and Regulations

Medicaid

Approved the following objectives regarding Medicaid to be included in FMA's 1979 legislative program:

- More adequate funding for the Medicaid program with particular emphasis on primary care.
- Revised management structure to provide more direction to the program.

Florida Neurosurgical Society

Expressed support for the Florida Neurosurgical Society in its efforts to revise the rules and regulations for Florida's Spinal Cord Injury Treatment Program so that major hospitals with adequate facilities can be approved as spinal cord injury centers.

Proposed Legislation

Approved Association policy regarding proposed legislation as follows:

- Opposed legislation that would establish a committee that would legislate hospital rates.
- Directed that legislation addressing specific problems of health care costs be developed.
- Opposed funding for a school of optometry
- Supported legislation prohibiting use of drugs by optometrists.
- Not support legislation requiring that each settlement of a PLI claim be registered in circuit court.

Council on Medical Economics

Second Surgical Opinion Programs

Reaffirmed FMA policy regarding second surgical opinions that:

The FMA believes each patient has a right to consult a physician of his choice. FMA believes each physician should give a patient his opinion concerning the patient's needs. FMA believes the principles of medical ethics already requires second opinion when the patient or attending physician believes this to be indicated. FMA believes the intrusion of a third party

into this relationship by insisting upon a second surgical opinion prior to elective surgery increases the cost of medical care and will not improve the quality of care which the citizens of Florida are now receiving; "and further to reaffirm the Judicial Council opinion that a physician's participation in a second surgical opinion program is not unethical, provided that, the program allows the patient reasonable freedom of choice of the physician."

Council on Medical Services

Tuberculosis Testing

Advised the Department of Education and the HRS program office that the FMA has changed its previous position regarding TB Testing of school personnel and recommends:

School personnel should be screened for tuberculosis on initial employment by tuberculin skin testing. Personnel currently employed should be tested if there is no record of a previous test. Reactors should be examined by a 14 x 17 chest x-ray and should consult with their physician regarding the advisability of isoniazid preventive therapy. If preventive therapy is completed, no further screening is required; if not completed, a chest x-ray should be required at least annually. Nonreactors need no further screening except when circumstances indicate a higher risk of acquiring infection such as known exposure and in certain high risk areas.

Childhood Cancer

Endorsed the state Childhood Cancer Program for classroom management of childhood cancer and recommended that the Department of Education and Health Program Office distribute information on this project to all Florida school districts.

School Physicial Examination Form

Endorsed the school physicial examination form proposed by the Committee on School Health and Sports Medicine to be utilized for both pre-school and athletic physicials.

MacDonald's Immunization Program

Voted to actively endorse and support the MacDonald's Immunization Program which is a national trust with the goal of immunizing at least 90% of all children by October, 1979. MacDonald's will offer a premium to all children who bring in an immunization certificate validated by the County Health Department or local physicians. Physicians may obtain MacDonald's "Good Patients" certificates by calling 1-800-342-2705.

NEW Recall Program

Approved in principle HEW's "recall" immunization program which is an effort to have children complete recommended immunization schedules.

Patient Identification Information

Approved in principle FMA policy opposing any regulations that would require the release of patient identification information in connection with mental health or drug abuse programs.

Private Rural Health Clearinghouse

Approved the concept of a privately funded clearinghouse for recruiting physicians to medically underserved areas.

Physicians Recruitment Conference

Authorized the Third FMA Physicians Recruitment Conference for communities in need of physicians to be held in early 1979.

State Health Plan

Requested the Department of HRS to send copies of any future proposed State Health Plan to the FMA and its component societies for review and comment prior to adoption and publication.

Council on Medical Systems

HSA Activities

Took the following actions regarding HSA activities:

Requested Florida's AMA Delegates to consider the most appropriate action to insure that the AMA place maximum emphasis on monitoring HSA activities both nationally and regionally in keeping state medical associations better appraised of what is taking place at the national and state level.

Requested county medical societies to appoint a key contact physician for each officer and committee chairman of individual HSA's.

Approved the state and local HSA Monitoring Plan proposed by the FMA Committee on HSA's be implemented and that each county society implement the plan at the local level, including attendance at monthly HSA regular meetings by county medical society executive staff whenever feasible.

Council on Specialty Medicine

Cerebella Stimulator Pacemaker

Advised the United States Civil Service Commission that the FMA has not taken a position with regard to Cerebella Stimulator Pacemakers but that the FMA's Council on Specialty Medicine has reviewed this procedure and has made the following observations:

- At the present time, the procedure is experimental;
- It is not universally accepted as found or valid medical treatment for the diagnosis or treatment for any specific diagnosis;
- The procedure is rendered within accepted professional medical standards in Florida.

Judicial Council

Disabled Physicians Program

Requested the FMA Judicial Council review and make recommendations regarding the development of a disabled physicians program in Florida. The FMA House of Delegates in adopting Resolution 77-17 directed the FMA Board of Governors study programs as developed in the state of Georgia and Washington to aid in the early diagnosis and treatment of disabled physicians and the feasibility of adopting such a program in Florida.



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When painful spasm
is the presenting
symptom...

. . . in functional G.I. disorders*

Bentyl®

(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-3497 (Y515A)

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION.

Brief Summary
INDICATIONS
For use as adjunctive therapy in the treatment of peptic ulcer.
IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION

Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy; hepatic or renal disease; ulcerative colitis–Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

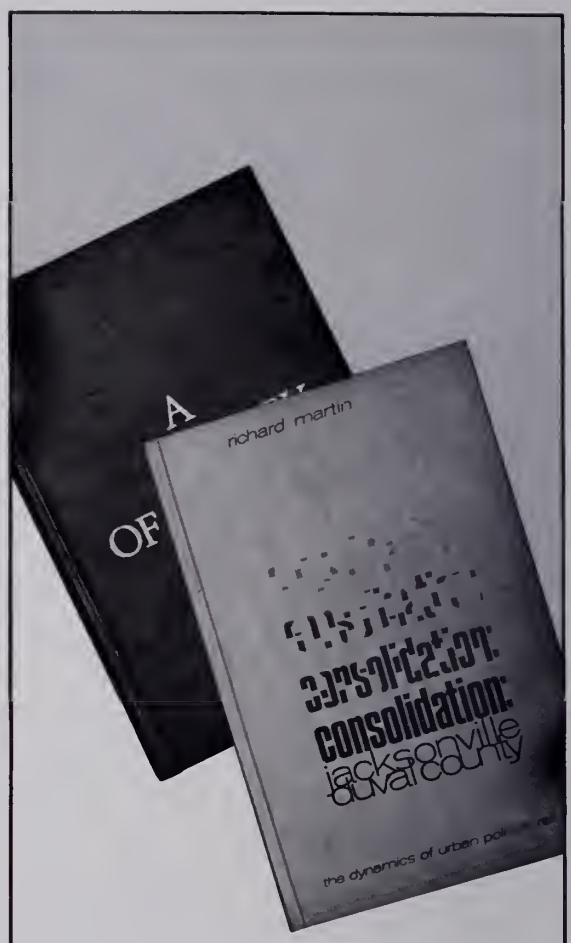
It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation, constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage. Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children.* 1 capsule or teaspoonful syrup three or four times daily. *Infants.* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE. The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1976

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30	Polycillin (250 mg.)	$8.70	Ampicillin (250 mg.)	**$2.40**	**$6.30**
100	Equanil (400 mg.) C-IV	8.09	Meprobamate (100 mg.) C-IV	**1.83**	**6.26**
100	Darvon Comp. 65 C-IV	7.83	Propoxyphene HCl Comp. 65 C-IV	**4.63**	**3.20**
100	Pavabid (150 mg.)	11.73	Papaverine HCl T.R. (100 mg.)	**4.33**	**7.40**
100	Thorazine (50 mg.)	6.03	Chlorpromazine HCl (50 mg.)	**3.23**	**2.80**
100	Librium (10 mg.) C-IV	7.11	Chlordiazepoxide HCl (10 mg.) C-IV	**4.89**	**2.22**

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The "Green Apple Quick-Step" didn't necessarily involve green apples...



Years ago, the cramps and pain of smooth muscle spasm and the embarrassment of associated diarrhea were sometimes referred to as the "green apple quick-step."

But green apples don't necessarily have anything to do with this common problem. No matter what it's called now, irritable colon and functional diarrhea are still very much a part of the everyday scene. Fortunately, so is Trocinate (thiphenamil HCl).

Trocinate acts rapidly to relieve the misery of smooth muscle spasm, and arrest acute functional diarrhea.* Effective blood levels can be achieved with Trocinate often within 30 minutes. And when effective, as little as two to four doses will bring relief.

One 400 mg tablet every four hours works for acute episodes. And once relief is achieved, it usually can be maintained with a reduction in dosage, utilizing the 100 mg tablets. Additionally, Trocinate is **not** an anticholinergic; a particularly significant benefit for patients with glaucoma.

So in your next few patients suffering the pain and embarrassment of functional diarrhea and smooth muscle spasm, consider a clinical trial with Trocinate. It means prompt relief for your "quick stepping" patients...even when there are no apples involved.

Trocinate®
(thiphenamil HCl)

...rapid relief for functional diarrhea

ACTIONS:
Trocinate is a potent antispasmodic and smooth muscle relaxant that acts like papaverine on smooth muscle. Trocinate exerts a strong local anesthetic effect on contact with mucous membranes.

INDICATIONS*
Trocinate is indicated for relief of smooth muscle spasm.

In Gastroenterology: for relief of pain and discomfort due to smooth muscle spasm associated with spastic colitis, irritable colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders.

LIMITATIONS OF EFFECTIVENESS
On the basis of the opinions of the National Academy of Science and National Research Council Committees and other information, the Food and Drug Administration considers this drug to be limited in its effectiveness, as follows:

Probably effective, as follows: May be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon). To be effective the dosage must be titrated to the individual patient's needs.

CONTRAINDICATIONS:
Trocinate is contraindicated in obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, paralytic ileus, pyloroduodenal stenosis, etc.); intestinal atony of elderly or debilitated patient; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS:
Use in Pregnancy—The safety of the use of Trocinate during pregnancy has not been established.

Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug may be inappropriate and possibly harmful.

DOSAGE AND ADMINISTRATION:
Adult: Initially, 400 milligrams. May be repeated four hours later. Trocinate acts very promptly and, when effective, relieves discomfort with two to four doses. Relief may usually be maintained with reduced frequency of dosage.

The safety and efficacy of Trocinate in children has not been determined, and Trocinate should not be administered to children.

MANAGEMENT AND OVERDOSAGE:
In twenty years of usage of Trocinate, side-effects have been so very infrequent that no typical symptoms and physical signs of overdosage have become known. Consequently, any untoward symptoms or physical signs should be counteracted by appropriate palliative therapy.

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How much is "too much" milk?

Milk, like many foods today, is being looked at much more closely than ever before by physicians and nutritionists.

And well it should be.

Because we recognize that too much milk, like too much of any one food, can fill a child up and consequently, can keep him from eating other foods he needs. Particularly, iron-rich foods.

But let's also make sure children get enough milk. Because milk supplies more essential nutrients per calorie than most other foods.

A child between the ages of six months and six years, for example, can get at least three-fourths of his daily dietary allowance for calcium, riboflavin, vitamins D and B_{12}, phosphorous, and protein from just three glasses of milk. And milk is also a good source of vitamins A and B_6, as well as thiamin and niacin.

That's why the U.S.D.A., acting on the recommendation of the National Research Council—National Academy of Sciences, has established these guidelines for milk consumption:

Children up to 6 years
Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on: 60 mg tryptophan=1 mg niacin

ndc **National Dairy Council**

Milk. Sometimes we forget all the good things it does.

"...a more satisfactory treatment..." [1]

VITAMIN C

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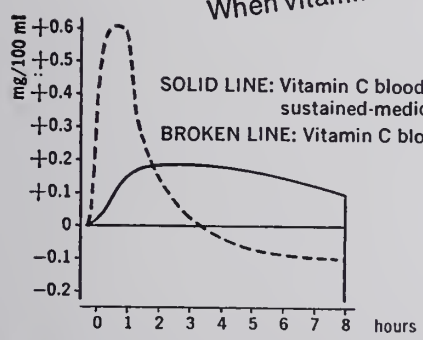
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Hypercalcemic Crisis in Primary Hyperparathyroidism

George L. Irvin III, M.D. and Ishmael J. Torres, M.D.

Abstract: Patients dying with extreme hypercalcemia occasionally have a potentially curable lesion which is often overlooked due to the uncommon association of parathyroid disease with this clinical state. The purpose of this paper is to (1) examine the incidence of this etiology in hypercalcemic crisis, (2) critically review our therapeutic efforts and (3) emphasize the importance of early surgical intervention. Of the 102 consecutive patients operated on for the first time with a diagnosis of primary hyperparathyroidism, five met the criteria for hypercalcemic crisis. Large volumes of parenteral fluids, furosemide, steroids, and renal dialysis were the treatment modalities. Definitive control of hypercalcemia was accomplished by surgical excision of a parathyroid adenoma. However, there was a marked difference in the pre- and postoperative morbidity and mortality. Three patients with surgical exploration delayed from eight to 25 days had significant morbidity including one death. Two patients were operated on within 24 hours of admission resulting in an excellent and uneventful postoperative course emphasizing the need for early diagnosis and undelayed surgical intervention in hypercalcemic hyperparathyroid crisis.

Within the past 12 months at our Medical Center, two patients dying with extreme hypercalcemia of undetermined etiology were found at postmortem examination to have large but unsuspected parathyroid adenomas. The diagnoses in these two patients were missed because severe hypercalcemic states are usually associated with far advanced malignancies, with or without osseous metastases and only rarely have they been recognized as late manifestations of parathyroid disease.

In order to examine the incidence of hypercalcemic crisis caused by parathyroid disease, 102 consecutive patients with a diagnosis of primary hyperparathyroidism undergoing cervical exploration for the first time at the University of Miami Medical Center were studied. Five patients in this group presented with criteria establishing the diagnosis of hypercalcemic crisis—namely, serum calcium levels greater than 15 mg/100 ml, deteriorating renal function, and progressive symptoms usually involving the nervous, cardiovascular and gastrointestinal systems.

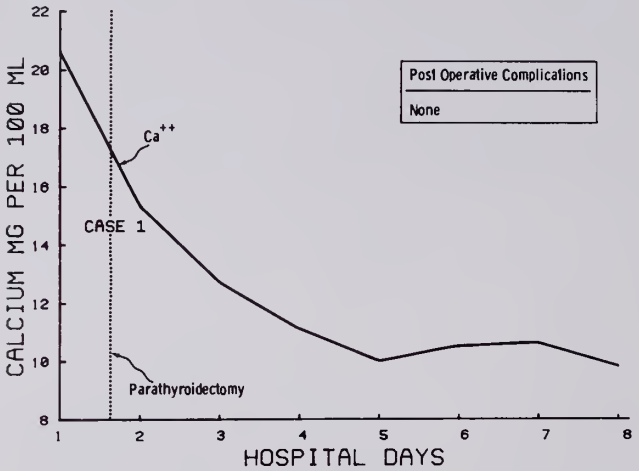
The diagnostic procedures used to rule out malignancy, treatment modalities used in an attempt to control the severe hypercalcemia, length of hospitalization prior to surgical intervention, and the operative procedures varied greatly and probably influenced the morbidity and mortality. Case histories are presented for clarity.

Report of Cases

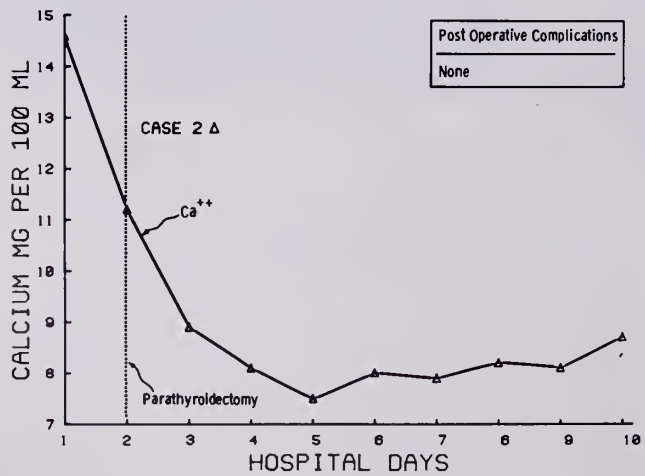
Case 1.—A 52-year-old black female presented with weakness, dysphagia, polydypsia, polyuria and a ten pound weight loss. She appeared oriented, although remote memory was poor. There was generalized muscle weakness and a smooth, non-tender mass was described in the cervical area to the right of the thyroid gland. Her blood pressure was 160/100. On admission, laboratory values were: serum calcium 20.6 mg/100, inorganic phosphate 3 mg/100 ml, creatinine 3.2 mg/100 ml, BUN 46 mg/100 ml, potassium 3 mEq/L, sodium 135 mEq/L, and alkaline phosphatase 225 units (N 30-80). Admission chest, abdominal and barium swallow x-rays were unremarkable. Two bone marrow aspirations were normal. This patient was treated with intravenous normal saline receiving a total of 7300 cc over a 15-hour period. She received Fleet's phosphosoda 5 ml (62.5 mEq PO 4) on two occasions and 1 gram of hydrocortisone. The serum calcium level decreased to 14.1 mg/100 ml as a result of therapy. Fifteen hours after admission a parathyroid adenoma

From the Veterans Administration Hospital and Department of Surgery, University of Miami School of Medicine, Miami.

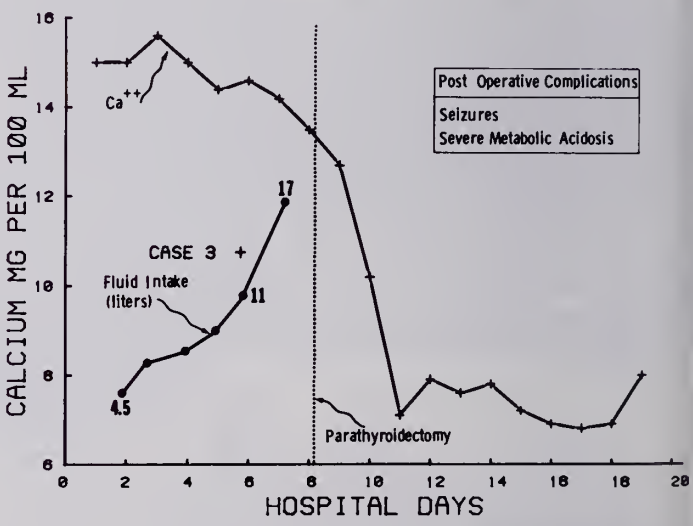
measuring 4x2x1.5 cm was excised from the area of the right upper pole of the thyroid. The procedure lasted 45 minutes and she tolerated it well. At the time of discharge on the seventh postoperative day, the serum calcium was 9.6 mg/100 ml and the blood urea nitrogen had decreased to 23 mg/100 ml.



Case 2.—A 72-year-old white female was very lethargic and mentally confused on admission. There had been complaints of generalized bone pain and weakness which had become progressively worse during the past two years. Anorexia and a recent ten pound weight loss were also described. One year prior to admission her serum calcium was found to be 17.2 mg/100 ml with a phosphate of 3 mg/100 ml, alkaline phosphatase 140 units (N 30-80), blood urea nitrogen 20 mg/100 ml, and creatinine 2.4 mg/100 ml. However, no treatment had been instituted prior to referral to our institution. Primary hyperparathyroidism was suspected and a brief but thorough work-up was initiated to rule out malignancy. Previous chest x-ray, skull and bone films, an upper gastrointestinal series and an intravenous pyelogram had been unremarkable. On this admission, her serum calcium was 15.5 mg/100 ml with a phosphate of 1.9 mg/100 ml. Blood pressure was 170/100. Initially, she was treated with intravenous normal saline and 5% dextrose receiving a total of 2500 cc over a 24-hour period. Medications included prednisone 5 mg, 10% kaochlor 45 cc, and 40 mg of oral furosemide. Twenty four hours after admission, a parathyroid adenoma measuring 4x3x2 cm was excised from the area of the left lobe of the thyroid. The procedure lasted 70 minutes. The postoperative period was satisfactory and her symptomatic hypocalcemia was well controlled with oral calcium supplements. She was discharged on the 11th postoperative day with a serum calcium of 9.4 mg/100 ml, a normal creatinine, and a much improved mental state.



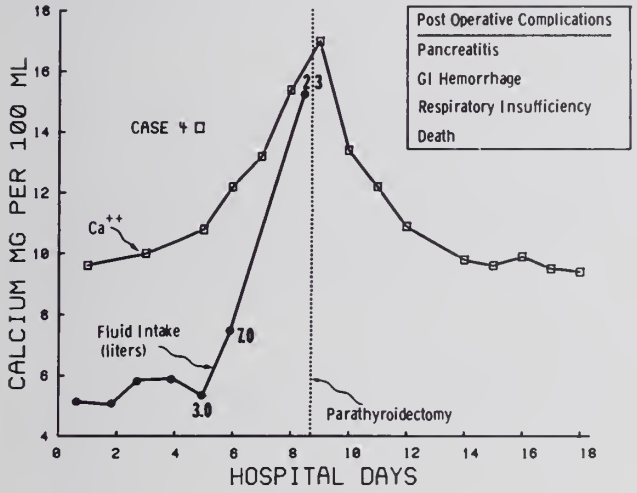
Case 3.—A 66-year-old male, Bahamian was admitted with a three-month history of anorexia, constipation, muscular weakness, dysuria, nocturia and a 40 pound weight loss. A urinary tract work-up revealed only occlusive bladder neck disease. On the second hospital day, serum calcium was found to be 15.6 mg/100 ml, phosphate 4.4 mg/100 ml, creatinine 4 mg/100 ml, and blood urea nitrogen 32 mg/100 ml. The patient became progressively confused and lethargic. He was treated with intravenous normal saline and furosemide. During the next six days, oral and parenteral intake progressively increased from 4.5 to 17 liters of normal saline per day with potassium and magnesium supplements in an attempt to control his increasing hypercalcemia. Furosemide was administered up to 240 mg per 24 hours. The serum calcium was thus lowered to 13.5 mg/100 ml, creatinine to 2.9 mg/100 ml, and blood urea nitrogen to 10 mg/100 ml. The work-up had included a nondiagnostic bone marrow aspiration and an intravenous pyelogram which showed only poor concentration. Metastatic bone series and hand films were unremarkable. Serum and urine protein electrophoresis were within normal limits. A parathyroid adenoma measuring 3.6x3.2x1.6 cm was removed from the left lower pole of the thyroid on the ninth hospital day. The surgical procedure lasted one hour and 20 minutes and the patient was under anesthesia for approximately two hours. The procedure was complicated by seizures and Cheyne-Stokes respiration which occurred in the immediate postoperative period. Arterial blood gases revealed a pH 7.18, pC02 26, p02 83, Hc03 9.5 and a base excess of -17.5. At this time, the serum electrolytes were as follows: sodium 158 mEq/L, potassium 6.6 mEq/L, C02 14 and chloride 130 mEq/L. The acidosis and electrolytic imbalances were corrected with difficulty over the next 24 hours. All neuromuscular dysfunctions disappeared during this time. By the fifth postoperative day, the serum calcium had decreased to 6.9 mg/100 ml and it became necessary to administer calcium gluconate parenterally. On the 14th day after surgery he was discharged on oral calcium supplements maintaining a serum calcium level of 8 mg/100 ml.

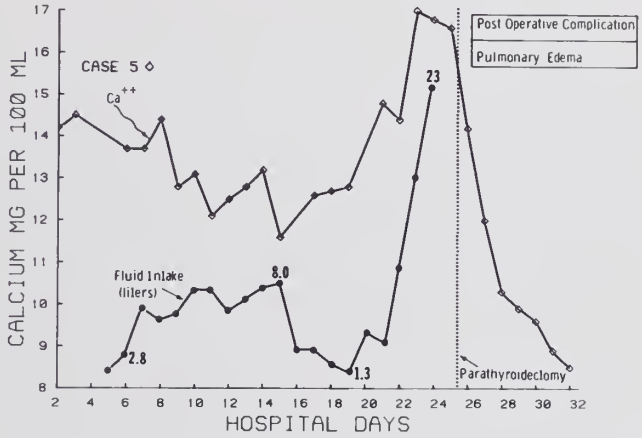


Case 4.—A 58-year-old diabetic male was transferred to this institution after having undergone an exploratory laparotomy and drainage of a pancreatic pseudocyst three weeks prior to admission.

The serum calcium had been found to be greater than 15 mg/100 ml on several occasions and he was treated with prednisone, Fleet's phosphosoda and intravenous normal saline. He was a known hypertensive and had a history of renal lithiasis for the past 11 years. On admission the serum calcium was 10 mg/100 ml, inorganic phosphate 5.2 mg/100 ml, creatinine 2.2 mg/100 ml, and the blood urea nitrogen 60 mg/100 ml. He was initially treated with oral and parenteral fluids in moderate amounts. Beginning on the fifth day of hospitalization, the serum calcium level progressively increased to 17 mg/100 ml despite large amounts of intravenous normal saline. Up to 15 liters per 24 hours were administered. He also received up to 120 mg of furosemide per day. On the eighth day after admission, a difficult cervical exploration lasting three hours resulted in excision of a parathyroid adenoma measuring 2x2x1 cm. Although serum calcium decreased to normal levels shortly after surgery, severe gastrointestinal hemorrhage developed on the fourth postoperative day which could not be controlled operatively. Continued diffuse hemorrhage, accompanied by respiratory insufficiency and hemorrhagic pancreatitis, resulted in his demise on the 11th postoperative day.

Case 5.—A 65-year-old black male presented with complaints of low back pain, weakness in the legs, nocturia, polydypsia, and a ten pound weight loss. A calculus in the left kidney had been previously diagnosed by intravenous pyelogram. On admission he was found to have a palpable nodule in the prostate. Serum calcium level at this time was 14.2 mg/100 ml and inorganic phosphate 2.5 mg/ml. A skull film showed a "salt and pepper appearance," but there was no evidence of Bence-Jones protein in his urine. Intravenous normal saline treatment was initiated and up to 8 liters per day were administered. Furosemide was given in small amounts on several occasions. During this time, the serum calcium decreased to a level of 11.6 mg/100 ml. Twenty days after admission he underwent a biopsy of the prostate. The intravenous saline had been discontinued. Two days after the biopsy he became febrile and lethargic. The serum calcium was again 14.7 mg/100 ml. Treatment with saline including potassium and magnesium supplementation was reinstituted at this point in amounts exceeding 22 liters per day. An adequate output was maintained with furosemide—up to 100 mg per day. While on this regimen, the patient underwent renal dialysis for two days when the serum calcium reached a peak of 17 mg/100 ml. A serious cardiac arrhythmia was noted and successfully treated on the day prior to cervical exploration. On the 25th day after admission, a parathyroid adenoma located near the left lower pole of the thyroid was excised. The immediate postoperative course was complicated by pulmonary edema which was successfully treated. The serum calcium level fell gradually over the next two days to low normal levels and the patient did well.





Discussion

Severe hypercalcemia, lethargy, generalized weakness, and mental derangement progressing to a comatose state along with deteriorating renal function are most often found in patients with terminal malignancies. That this syndrome is seldom recognized as a complication of parathyroid disease can be explained by a nonparathyroid etiology in 80% of patients with hypercalcemia,[1] and by the fact that except for an occasional case report,[2] there has been little emphasis in the recent literature associating hyperparathyroid disease and hypercalcemic crisis.

The present day incidence of hypercalcemic crisis in primary hyperparathyroidism has not been established. A review of the subject in 1967 by MacLeod and Holloway[3] documented only 86 cases with a reported mortality of 60%. Yeager and Krementz[4] in 1971 reported six cases of acute hyperparathyroidism found at necropsy or surgery in 100 hyperparathyroid patients at Charity Hospital over a 28-year period. In 1972, Kaminski and Willman[5] added 24 additional case histories bringing the collected series to 110 with a mortality of 53%. In the present series of 102 consecutive

patients operated on for the first time with a diagnosis of primary hyperparathyroidism, five met the criteria for hypercalcemic crisis. This term has been loosely established in the past but is defined here, as by Payne and Fitchett,[6] with rising serum calcium levels above 15 mg/100 ml, alterations in renal function with rising blood urea nitrogen concentrations or creatinine levels and progressive changes in the patient's general condition, especially with acute symptoms involving the gastrointestinal, cardiovascular and central nervous systems.

The 5% incidence reported here is higher than expected from previous reports and may not hold up in future series in that with the wide use of automated serum analyses, more patients with hyperparathyroid disease may be treated in an earlier stage of their disease, thereby avoiding such a devastating effect of long-standing hyperparathyroidism. However, Coffey, Lee and Canary[7] have recently found an 8% incidence of impending or overt acute hyperparathyroid crisis in 200 surgically treated patients at the Georgetown University Hospital which suggest the syndrome is more common than generally recognized.

The management of severe hypercalcemia by nonsurgical means has been effective with the use of many treatment modalities as summarized in review by Goldsmith.[8] The most widely used is that of large volumes of normal saline administered intravenously accompanied by a diuretic, such as furosemide or ethacrynic acid. Since there is some evidence that furosemide acts alone to increase the calciuric effect on the kidney, [9] this diuretic was used in our patients along with the liberal employment of intravenous normal saline. Potassium and magnesium supplements were added to this regimen and were monitored along with serum calcium levels. Two of our patients received an initial single dose of steroids without measurable effect, and one patient was subjected to two days of renal dialysis through a Scribner shunt to reduce a progressive increasing serum calcium despite adequate hydration and diuresis.

Definitive control of hypercalcemia was accomplished in all five patients in this series by surgical excision of a single, large parathyroid adenoma. However, there was a marked difference noted in the outcome as measured by pre- and postoperative morbidity and mortality. This difference appeared to be related to the length of time taken to establish the diagnosis before subjecting the patient to surgical exploration concomitantly with the amount of fluid and diuretic therapy used in an attempt to control the hypercalcemia.

Two patients (1 and 2) were admitted with extremely high calcium levels and central nervous system symptoms. They were both operated on after a rapid but thorough work-up to rule out malignancy within 24 hours after admission. Both patients responded well to hydration with an acute drop in serum calcium levels of 6 and 2 mg/100 ml. This fall continued postoperatively to normal or to hypocalcemic levels requiring temporary replacement therapy in one case. The results were excellent in these two patients and their postoperative courses were uneventful.

On the other hand, the three patients who experienced a prolonged preoperative hospital course (8-25 days) during which extensive diagnostic tests were performed to rule out malignant disease had less satisfactory results. In an attempt to control the persistent and progressive hypercalcemia during this time, extreme hydration with diuresis was the treatment of choice. Preoperative morbidity seen in the patients undergoing this therapy included hypokalemia, cardiac arrhythmias, progressive mental depression, and aspiration pneumonia. These patients also had severe postoperative complications including severe metabolic acidosis, seizures, pulmonary edema, hemorrhage from stress ulceration, recurrent pancreatitis and in one case, death.

Andersson and Bergdahl[10] have recently called attention to the fact that parathyroidectomy for severe hypercalcemia of malignancy is of little or no value. Despite this, these authors favor cervical exploration if acute hyperparathyroidism cannot be excluded and our data support their approach. It would appear that a rapid but thorough work-up to rule out an obvious malignancy, an attempt at temporary control of the severe hypercalcemia by hydration, followed by expeditious cervical exploration offer the best and most uncomplicated course for patients in hyperparathyroid crisis.

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Treatment of Advanced Cutaneous Neoplasms

Mutaz B. Habal, M.D.

Abstract: Cutaneous neoplasms are seen frequently in our geographic region due to the continuous exposure to the solar radiation. The lesions are most frequently seen in the face and the skull. The accepted mode of treatment is surgical extripation with "tumor-free margins." This mode of therapy offers a cure rate to almost all patients; however, advanced and extensive neoplasms are seen less frequently. These neoplasms reach a large size primarily due to neglect and procrastination by the patient to reach the treating physician. A less common cause is inappropriate and incomplete treatment. These lesions can be removed surgically and the defect resurfaced with split thickness skin graft. When vital structures are removed for tumor involvement as part of the resection plan, a full thickness flap is used from distant or adjacent sites. The first mode of coverage is preferable for it gives the physician a better region for observation, especially when local recurrences are to be feared.

Skin cancer is seen frequently in the southern regions of the United States. Continuous exposure to solar radiation makes the head and neck region the most common site for such tumors. They are usually seen by the treating physician early in development and any form of appropriate therapeutic modality provides a permanent cure. The cutaneous tumors are termed extensive when they are more than 5 cm in diameter or 10 cm^2 in surface area.

In the last four years we have seen 14 patients with extensive tumors. Each patient had a selected, individualized treatment plan based upon recommendations of the local Tumor Board. The small number of cases makes any statistical analysis for comparing the various treatment modalities impossible.

When first seen, these tumors are extensive because of patient neglect, fear of being subjected to an operative procedure, improper education, and lack of guidance from members of the family. The patient usually seeks help from the physician because of other reasons, i.e., weakness, foul-smelling odor, or local destruction of adjacent vital structures (Fig. 1). The head and neck skin tumors behave biologically different from other neoplasms in the body. These tumors are locally invasive, destructive, and rarely metastasize, except as a terminal event. Improper treatment allows such tumors to become out of control locally. Although two patients in our series had such events, this last cause is the exception.

Clinical Tumor Biology

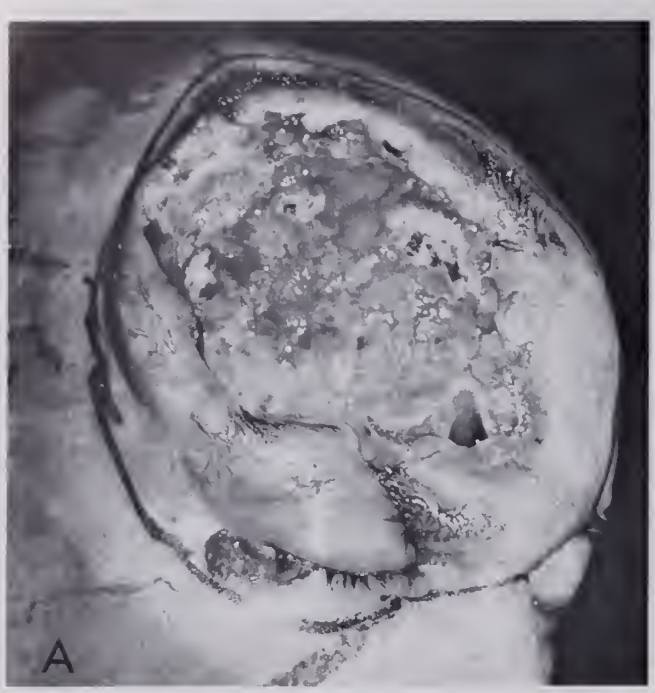
Site. The head is the most common site for advanced cutaneous neoplasms. Tumor growth appears to have most preference for the upper part of the face (craniofacial junction zone). The extensive skin tumors usually start as a small ulcerating or fungating irregular discontinuity in the skin. The biologic behavior, when untreated, leads to progression of the lesions, an increase in size that becomes destructive and locally invasive and later probable ulceration or bleeding. These tumors rarely metastasize to distant sites such as the lung or the liver. An increase in size usually results in destruction of adjacent structures. Membranous bones in the craniofacial area are devoid of lymphatics so destruction is usually by local extension and invasion.

Region. Tumors over the skull and forehead extend through the bones, invading down through the dura. Once the dura is reached, the tumor extends over it without going through the lining. The dura acts as a barrier and the brain is almost never involved. Such biologic behavior was noticed in all our patients. The orbital region is the next area that tends to be invaded by extension over the periorbita. Competition for this tight space produces extensive dislodgement of the orbit with eventual loss of vision on the affected side and classic proptosis. The nose and maxillary sinus are next in line for invasion. A tumor in the maxillary sinus involves the whole region of these membranous bones, producing an obstruction with continuous infection.

Tumor histology. Basal cell carcinoma and squamous cell carcinoma are the most common tumors seen. Very rarely are other forms encountered. We have

From the Department of Surgery, Head and Neck Tumor Board, University of Florida College of Medicine, Gainesville.

This article is based upon a presentation at the 8th Annual Radiation Therapy Clinical Research Seminar, April 20-22, 1978, at the University of Florida.



A. The extent of the tumor when the patient was first seen.



C. Fascia lata was used as a free dural graft to reconstruct the defect created by the resection.



B. The tumor was resected, full-thickness, with tumor-free margins in three dimensions. Note the defect after removing the involved dura. The outer cortex of the brain was free of disease. The tumor was resected en bloc.



D. The whole extensive defect was closed with a rotation flap of the skull — an adjacent tissue — for coverage. The final loss of function was the eye involved with disease.

Fig. 1. — A patient with an extensive advanced basal cell carcinoma of the forehead and upper orbital region. The tumor is 14 years old and started as a small ulcerating lesion near the hairline. It extended deeply to erode the neurocranium and spread over the dura.

seen one patient with advanced malignant melanoma. This tumor usually disseminates to distant sites rather than behave in a local and invasive manner. Such behavior is very unusual biologically. Histology may vary from poorly differentiated to well differentiated squamous cell carcinoma. The degree of differentiation has no relationship to extent of invasiveness. A change in the histopathological diagnosis of the relatively dormant basal cell carcinoma to squamous cell carcinoma was seen in three patients as the tumor progressed over the years and became more invasive and locally destructive.

Treatment

The most accepted form of treatment of these advanced tumors is surgical extirpation with good free margins, in essence, a coring procedure of the malignant tumor. The objective focuses on removing all tumor-bearing tissues and closing the surgical defects primarily with either skin grafts or local flaps when indicated (Fig. 1). Radiation therapy plays an integral part in treatment. If the tumor involves only the skin, the major treatment may be primarily radiation therapy. This offers the best cosmetic results. Radiation therapy, on the other hand, can be used as an adjunct to surgery in the following forms of application.

1. X-radiation therapy is used for lesions that are flat-surfaced, exophytic, localized and do not show any bony invasion. It can be used as a primary mode of therapy and the tumors are cured after such treatment.

2. X-radiation therapy is given in the form of postoperative treatment for patients who have more residual tumor in nonresectable areas of the face, or if the tumor has extended via the bony canals of the skull to the basilar structures of the skull. Such therapy augments the surgical treatment and offers a better cure rate.

3. X-radiation therapy is given to render nonoperable lesions "operable." Such treatment, given in the form of preoperative radiation, is very helpful in patients with very large and fungating tumors. When the tumor is sensitive, there is usually a very small defect left that can be reconstructed promptly. Even though reconstructive procedures may become more complex because of the biologic effect of radiation on the soft tissue, benefits gained by the patient overcomes this last point.

4. X-radiation therapy is also used for palliation, to decrease the ulceration or discomfort the patient has in largely invasive and advanced disease when other treatment modalities are nonapplicable.

The aim of surgical therapy is to remove all tumor and cover the defect primarily. In the area of the orbit or the neurocranium, large open surfaces can be covered with split thickness skin grafts. Tumor-involved dura is resected and a dural graft is used to close the defect. If the dural graft is large, a full thickness flap coverage will be needed since such grafts will not support a split thickness skin graft (Fig. 1D). Two forms of free dural grafts are used: a viable autograft removed from the fascia lata, or a freeze-dried preserved dural allograft. Both are used with equal impunity (Fig. 1C).

Bony framework reconstruction is not done until an appropriate time of observation reveals no evidence of disease. In our experience, this is usually a period of 18 months. Over 80% of local recurrences manifest themselves within this time. For complete restoration of contour we have used full thickness flap coverage in a delayed form of reconstruction.[1] Adjacent flaps from the deltopectoral region are the most versatile. We try to avoid any marginal or local flaps, especially flaps in the region of the head, to keep from producing one deformity to correct another.[2] Free flaps have been used with microvascular anastomoses; the groin flap or the tensor fascia lata are most ideal. Using macroscopic anastomoses, the omentum is used as a free graft and, after completion of the anastomoses, split thickness skin graft is applied over the omental graft to achieve complete coverage and closure of the defect.

Topical chemotherapy has no place in treating extensive cutaneous malignancies. Such agents should be deferred to small ulcerating lesions only. Intralesional injection with 5-fluorouracil has a questionable place. This mode of therapy is usually reserved for small and noninvasive lesions. There is no indication for systemic chemotherapy except in terminal and hopeless conditions as palliative therapy.

Discussion and Conclusions

Extensive advanced cutaneous neoplasms are treatable. Their most common site is the upper part of the head (craniofacial junction zone). Basal cell carcinoma and squamous cell carcinoma are most common. These tumors are invasive and destructive and may be fungating or ulcerating. When secondary infection "sets in" in an open area, it complicates the problems with a foul-smelling odor from the surface of the tumor and the continuous oozing of blood that makes the patient anemic. Ulceration and destruction of cranial bones and the maxillary sinus have been observed in our series. The slow and progressive breakdown and sequestration of the cranial bones with dural exposure fortunately does not lead to meningitis in most patients.

A final note to remember: an advantage of using a split thickness skin graft is that it allows the treating surgeon an open thin surface to observe for any local

recurrences. If these should arise, the selective form of treatment can be implemented for each patient. Patient selection is the key to treating such complex and rare tumors. When indicated, and in very rare instances, full thickness flap coverage is used.

Summary

Cutaneous neoplasms are commonly seen in our geographic area. It is preferable to treat such tumors early. When left untreated, they advance and progress and destroy adjacent structures before metastasizing. Treatment includes wide excision with radiation therapy as an adjunct. This form of treatment is used on selected patients. A final note to remember is that these tumors are invaders if left untreated and can lead to death.

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Psychotherapeutic Games

Lawrence Weathers, Ph.D.; Jeffrey Bedell, Ph.D.; Herbert Marlowe, Ed.S.; Richard Gordon, M.D., Ph.D.; Julia Adams, M.A., and Valerie Reed, M.A.

Abstract: This report presents an innovative treatment technique which can be adapted equally well for mental patients of all ages in residential, day treatment, or group outpatient programs. Florida physicians are being called upon to treat deinstitutionalized psychiatric patients who previously resided in mental hospitals. Deinstitutionalization has thrown discharged patients into communities without providing adequate aftercare and related support. Psychotherapeutic games offer an effective, inexpensive method which can help keep these patients in the community and teach them to function as usefully and happily as possible.

"Tell the group what you would change about yourself if you could change one thing." This request is one a psychiatric patient might select when drawing a card in "Talk One," a psychotherapeutic game employed in a residential treatment unit at a Florida mental hospital.

Gaming dates back to the Prussian war games which were analogous to chess. Contemporary adaptations have been applied in educational and business settings as tools for teaching and assessment.[1, 2] Because games can provide a simulated life experience, they offer an innovative approach to skills training in psychotherapy.[3] Gaming also provides a useful research environment in that what takes place in the therapeutic situation is controlled by the structure of the game, and the extent to which the game reflects the real world can be manipulated.[4] Clinically, games are being developed at the Florida Mental Health Institute (FMHI) to provide training in communication, problem solving, self-assertion, self-medication, leisure skills, family living, and other areas. In treatment, games are (1) applicable in a wide variety of settings; (2) designed to encourage psychological growth and development of a variety of skills; (3) cost effective — as many as 32 patients at a time are engaged in treatment by a single relatively unskilled staff member; (4) "fun" — they provide a relaxed and highly motivating environment for the acquisition of skills; (5) self-motivating — players help themselves and other participants. The structure of the game encourages responsibility. When patients must depend on staff, their feelings of helplessness and inadequacy are reinforced. The games' structure, concreteness, and simplicity enable patients to interact therapeutically with each other. The content and process are designed so that a patient's self-esteem is enhanced rather than diminished. Furthermore, peer pressure ensures active participation of everyone, both in taking turns in playing and in grading other players' responses.

From the Florida Mental Health Institute and University of South Florida, Tampa, and University of Florida, Gainesville.

Role of Staff

Staff participation in gaming therapy is minimal and requires little sophisticated training. Staff are instructed as part of their inservice training in the operation and rationale for each game. They provide didactic instruction to patients regarding the skill being taught in each game session. They explain rules for conducting each therapy game to patients. They observe while patients operate the game according to rules; patients instruct each other and provide feedback to each other in accordance with the clear guidelines outlined by staff and provided in written form with the game. Staff answer questions regarding operation of the game. Occasionally, they may serve as referees helping interpret rules while the game is in progress, resolving disagreements between players regarding matters like accuracy of a vote, and explaining the meaning of a stimulus item or other procedure in the game.

As may be seen in Figure 1, the procedures for "selecting behavior from hierarchy," "modeling behavior," and "skill building" proceed in an identical manner for both leader-led treatment and gaming. However, "prompting," "rehearsal," "shaping," and "providing feedback" for differential reinforcement, which are critical working elements in skills enhancement, based directly on experimental learning research, are built into the structure and content of the game. They require no participation of the group leader. Thus minimally trained therapists can perform as well as experienced professionals, since they are called on to do little more than set up, explain, and proctor the game. In many treatment settings, such as when language difficulties introduce barriers between foreign born

FIGURE 1
A Comparison of Contemporary Leader-Led and Game Procedures for Skill Enhancement

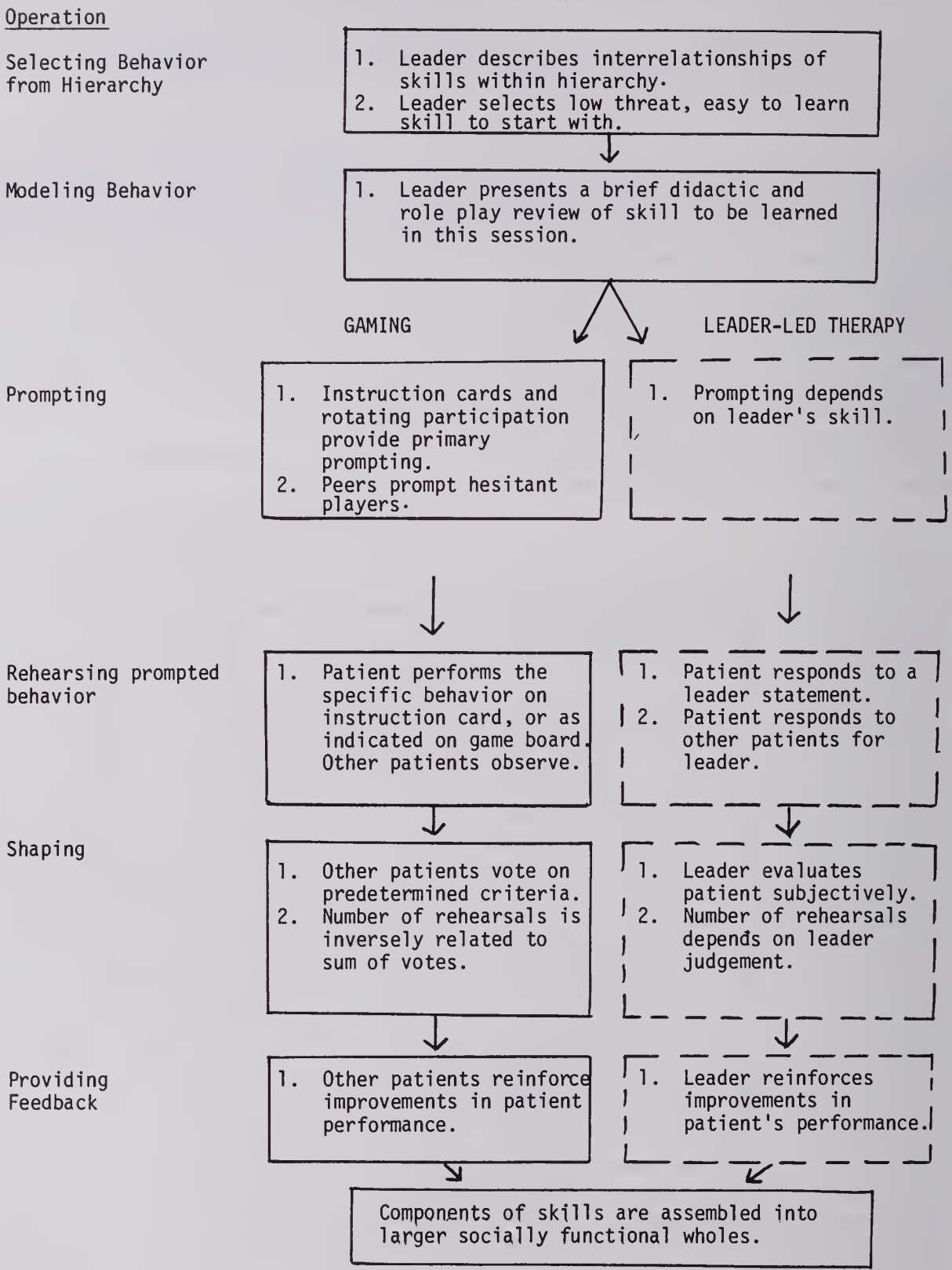


Fig. 1. — A comparison of contemporary leader-led and game procedures for skill enhancement.

therapists and native born patients, game playing may increase the quality of psychotherapy available to patients. It certainly increases cost-effectiveness and consistency in the treatment process. The high level of structure and independent operation of the game does not accommodate therapist modification to suit individual client needs; however, if highly skilled therapists are available to provide sophisticated clinical discriminations, individual sessions may be conducted to supplement the gaming sessions.

FMHI experience has been that patients require little or no help from staff when operating the games. On occasion, when a staff member is delayed in attending a session, the patients proceed to set up the games and commence play quite effectively without him.

Implications for meeting the treatment needs of patient groups are obvious, especially in state hospitals and other settings, including communities of deinstitutionalized chronic schizophrenics, where shortages of trained mental health professionals result in little or no therapeutic intervention for thousands of patients. Nurses, paraprofessionals, and volunteers easily learn to conduct this kind of skill-oriented, skill-enhancing therapy utilizing the game format. This is one kind of new service delivery technology called for by George Albee in 1959 when he predicted the inevitable deficit in high level mental health practitioners and the urgent need to develop new service delivery models which enlist nonprofessional manpower resources.[5] Physicians who provide medical care and psychotropic drug management to these patients may wish to consider prescribing psychotherapeutic games as part of their treatment regimen.

Communication Games

The communications game series will serve to illustrate the therapy model. Eight board games of increasing difficulty facilitate learning of three basic communication skills: self-disclosure, listening, and feedback.[6,10] Didactic lectures teach patients these concepts, alert them to "road blocks" that prevent effective communication, and explain nonverbal communication through the use of body language.

Self-Disclosure

The first skill introduced is self-disclosure, a means of communicating to others one's thoughts or beliefs. Two games, "Who I Am" and "Talk One," get players to talk about themselves by using "I" messages. The first, "Who I Am," increases awareness of interests and associated feelings. The materials consist of one "Who I Am" board for each group of four players, a set of "Who I Am" cards, $1,000 in play money, and four sets of vote cards. (Fig. 2.)

FIGURE 2

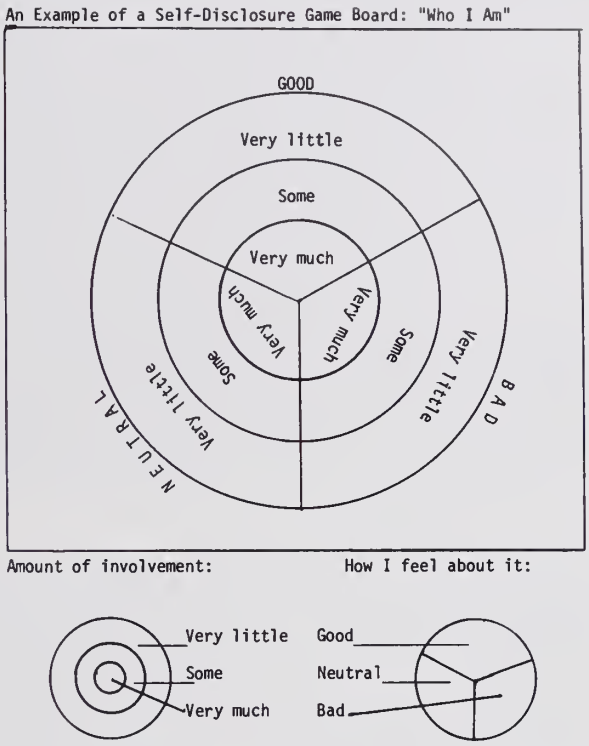


Fig. 2. — An example of a self-disclosure game board: "Who I Am."

The player selected as game manager sets up the game and reads a statement to the group that each card contains a word that is associated with people and which has impact on their lives. The cards contain words such as "garden," "sister," "religion." The circular board is divided into three color coded segments — "bad," "neutral," and "good." Each segment cuts through three concentric circles labelled "very little," "some," and "very much," which apply to the importance of the word to the player. The first round starts with the shortest player (or youngest, or oldest) drawing a card from the deck. He looks at the word, rates its importance, and identifies the appropriate color coded section of the circle. Next he decides what his feelings are about the card, "turned on," for example, and places the card on the appropriate section of the board. He then explains to the group why he placed it there and how he feels about its being on that particular spot. The vote caller then calls for a vote by all persons other than the player. Each person selects a vote card ("O" = poor response, "1" = acceptable response, "2" = excellent response) and places it face down in front of him. When all decisions are made, the cards are turned over.

Votes are cast according to a clearly defined outline for rating self-disclosure. The most complete response includes the following components: (1) acceptance of ownership of the statement by using "I;" (2) behavioral specificity, defining clearly what specific people and situational factors are important, rather than making vague or global remarks; (3) inclusion of how the speaker feels, what affect (happy, sad, angry, content) is associated with the area in question;[11] (4) clarity as to the speaker's wish or desire regarding the future of the described experience or activity.

The vote recorder sums and records the votes, and the player receives from the banker play money equal to the total votes received. The round continues with the player to the starter's right relocating the same card to reflect his own interest and feelings. This continues until all four players have responded to the card. A new card is then drawn and a new round begins. The game ends when the allotted time period is up, and the player with the most play money wins.

The games are effective in maintaining patients' interest; they often want to continue after the allotted three-hour time period is up. This is especially true at state hospitals where patients frequently request opportunity to play the games. For many patients the game setting represents the first time they have held a position entailing responsibility. Their self-sufficiency is enhanced as they give and receive feedback; they develop feelings of mastery from learning to do something well and having their accomplishment confirmed.

All the communications games are structured so that the patients begin with relatively low level challenges and progress to situations requiring greater risk-taking and/or more complex skills. For example in "Talk One," at the least difficult level the patient may be asked to tell the group about his favorite time of day, or how he feels about sports. In the middle level he may draw a card requiring that he describe the unhappiest moment of his life, or the hardest thing he ever had to do. At the hardest level, self-disclosure is pushed to the limit with cards that ask the patient to tell the group what he is most ashamed about in his past life, or how he feels about his sexual adequacy.

Listening

The listening skills games follow a similar pattern. In "Listening One" and "Listening Two" the focus is on the basic communication skills of paraphrasing, asking open questions, and reflecting feelings. Paraphrasing is repeating what another patient says using different words. An open question is one which helps the patient explore his own interests and feelings more fully, rather than forcing a "yes" or "no" response, or any certain answer. Feeling reflection involves a patient expressing understanding of how another patient feels about what he is saying.

One player draws a "statement" card that instructs him to role-play a simple situation. The situation may be relatively innocuous such as "I can't believe this Florida weather," a serious concern such as "I often worry about what will happen when I die," or an aggressive comment like "In your ear, wise guy." A second player, selected by a roll of dice, draws an "instruction" card which tells him to paraphrase the statement, ask an open question, or reflect the feeling. The other players vote on the adequacy of the response, and points are awarded accordingly. Here again, specific outlines for evaluating the patient's response are provided to guide the voting.

Feedback

Feedback is a special form of self-disclosure in which one patient reveals his reaction to another patient's behavior.[12] "Feedback One" and "Feedback II" provide players with the opportunity to practice telling other players how they perceive them and how they interpret and experience their behavior.

Players draw cards which instruct them to provide feedback to another player, for example, "Tell the other person how you see him/her deal with embarrassment," or "Tell the other person what he/she does that you like best." A few cards instruct the player to make self-disclosure statements such as "Tell the person on your right how you feel in giving him/her feedback." As in all the games, player votes determine the points scored.

In "Talk II," all the major communications skills are practiced. One player self-discloses, his "partner" listens, and the remaining players give feedback, which determines the player's score and the movement of his marker on the game board. "Communications One" provides another synthesis, requiring players to practice feedback, I-messages, and active listening. By the end of a nine-week program, patients have experienced intensive training in self-disclosure, active listening, and feedback skills which help them break through the communication barriers which have contributed to their psychiatric disability.

Problem-Solving Games

Problem-solving is another skills training area where gaming therapy is being experimentally applied. In the FMHI's short-term (9 weeks) program, problem-solving skills are taught simultaneously with communication skills. When longer periods of hospitalization with less intact patients are involved, communication skills might

be taught first as they are more basic and are required for effective problem-solving.[13]

The problem-solving sequence consists of six games which take patients through the four steps of problem-solving: problem recognition, problem definition, alternatives generation, and decision. The problem recognition process teaches the patient to acknowledge his/her problems, accept responsibility for them and establish priorities for dealing with them. In problem definition the patient learns to break down a problem into its component parts and to establish a goal-oriented approach to finding a solution. The objective of the alternatives generation process is to teach six different methods of developing possible solutions to problems: brainstorming,[14,15] producing an idea checklist, minimizing hindering factors, or maximizing helping factors, changing frame of reference,[16,17] solving analogous problems, and problem diagramming.[18,19] Finally, in the decision process, alternative solutions are evaluated and the best one chosen.

In the problem-solving series a subjective component is being developed in which patient players learn to recognize and work through their personal real-life problems while playing the games. Four games and three simulation exercises are being developed along with supportive didactic material. A "problem journal" is used so that the player's own problem can be carried through all four stages of problem solving. This format contrasts somewhat with that of communication games which focus mainly on a process-oriented approach. It also differs in that the problem-solving sequence uses a balanced program of simulations and games, rather than only the structured games format described in communications training. The advantage to including role-playing is that it more closely represents a real-life setting, with the patients acting out the problem solution in addition to solving it cognitively. Role play simulations are used in several other skills training groups, including assertiveness training, nonverbal training, sex role education, as well as in traditional communication training.

Assertion

Assertion skills are taught in a 23 session program which incorporates lectures, group discussion, videotape vignettes and responses, and role-playing. Five games are used to augment this training. They help patients learn to differentiate between passive, assertive, and aggressive behaviors.[20] In assertion games, they practice and experience making responses in these three styles.

Assertion II, for example, gives players a variety of role-play situtations in which they are instructed to respond passively, aggressively, or assertively. Examples of some of the instructions are the following: you are offered a good job in another state, but your spouse doesn't want to move; after paying the TV repair bill, you find that the set now has the same problem as before, so you telephone the repairman; you just got your friend's car in an accident, which was your fault, and now he/she is asking entirely too much in terms of compensation; your sibling has been watching TV all morning and now you want to watch a different show; and your boss is trying to get you to work late and you've made plans for the evening.

Through assertion training patients learn to get their needs met in a direct manner. They develop respect for themselves and others which helps produce a more positive self-concept needed for recovery from psychiatric illness.

Self-Medication Games

At the FMHI, staff continue to find new uses for game therapy. Patients learn to take their medications properly through games.[21] "Meds Bingo" teaches drug classification, therapeutic effects, side effects, drug interactions, and precautions. In "Name That Pill," patients learn visual identification of different medications and practice reciting the information they learned in "Meds Bingo." By the time they have finished with their self-medication training program, they have become informed and responsible self-medicators. They no longer need to queue up at the nursing treatment each day but can keep their own medications, take them home weekends and are prepared for the unsupervised situation they will experience upon discharge from the hospital.

The importance of this training is obvious when one considers that a major cause of recidivism among chronic schizophrenics is discontinuation of the medication regimen. This technology, incidentally, may readily be adapted to training for self-medication for patients with other chronic disorders — diabetes, hypertension, arthritis.

The gaming model can be applied to other skills training programs such as use of leisure time, heterosexual relationships, and family living. The gaming sequence and content are flexible and can be modified to suit the specific needs of a particular program. For example, the package can be expanded to include more elaborate simulations to provide a greater variety of experiences to participants. To add incentive, a token economy system can be tied into the game format by converting the play money won in the games into tokens that may be exchanged for toilet articles, food and social events of interest to the patients.

Evaluation

An FMHI treatment system has reduced rehospitalization of psychiatric patients discharged from a state institution by 80%, from 33% among 42 control patients to 6.8% in a randomly selected experimental group of 44 patients. This treatment includes psychotherapeutic games as a component. A companion paper on Reducing Rehospitalization of State Mental Patients more fully describes this system.[22] The greatest measured contribution to date of the gaming approach is in reducing the need for expensive, hard-to-find professionals to serve in the state mental health system. In gaming, patients provide their own therapy. Only a minimally trained staff attendant is needed to monitor therapy for 32 patients. In comparison, group psychotherapy requires a trained professional who can treat only eight to 16 patients at a time.

At present, the only data on specific skills training that are available for analysis come from the communication skills series. The patient groups as a whole benefit significantly from this residential training, with mean scores on a communication behavioral assessment scale increasing from 70.1 to 78.9 ($F(1, 30) = 14$, $p < .001$). Analysis of variance showed no significant difference between groups who obtained training through psychotherapeutic games and those who were trained in conventional therapist-led modules. Data on problem solving and other skills training are being collected.

Most of the games can be adapted to accommodate the needs of other treatment facilities. For example, the content of the communications series can be focused around the needs of geriatric patients, adolescents, detained criminals, and deinstitutionalized patients living in the community. A number of agencies in Florida have begun using games in their programs. Their effect has sometimes been dramatic. Florida State Hospital (Chattahoochee) introduced part of the communication series to a group of chronic mentally ill offenders hospitalized in most part for at least two years with minimal interaction among and benefit to patients. Upon beginning to play therapeutic games, the patients were actively communicating, talking about themselves to each other and to staff.

Other facilities which have adapted the games to their service needs include Northside Community Mental Health Center, Hillsborough County Children's Services, Northeast Florida State Hospital, and Lee County Community Mental Health Center. Lake City and Avon Park Community Colleges have incorporated the communication series into their AA and AS level human service worker training programs, and state mental retardation trainers use the games for providing their personnel with continuing education.

The wide range of settings which are already making use of games reflects the flexibility of this innovative technique. The technology has received favorable responses from treatment and training personnel in these varied settings. Research at the FMHI is measuring long-term treatment effectiveness as well as cost effectiveness. The potential impact of game technology on state mental health systems is great. Staff are modifying the games and expanding their range of applications to other human needs where the game format can be tested. In any event, psychotherapeutic games appear to help train patients for deinstitutionalization and may contribute to their successfully remaining in the community.

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(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®

References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

Whether overweight is a complicating factor... or just uncomplicated overweight.

Tenuate® Dospan® (IV)

(diethylpropion hydrochloride NF)

75 mg. controlled-release tablets



A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

Merrell

For prescribing information see opposite page.



EMPIRIN® COMPOUND
ℂ CODEINE

Each tablet contains: aspirin 227mg, phenacetin 162mg, and caffeine 32mg, plus sublingual/buccal activity as indicated by analysis: *4—60 mg; *3—30 mg; *2—15 mg; and *1—8 mg of codeine. (Warning—may be habit forming.)

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

SPECIAL ARTICLES

On Reading the Medical Literature

Arnold S. Relman, M.D.

It is a great privilege to be invited here to share this day with you; however, while appreciative of the honor, I am acutely aware of the responsibilities. I am expected to say something wise and witty and, above all, brief. I doubt that I shall meet those expectations, except for the last. I intend to speak no more than 20 minutes, for my message to the graduating class is succinct and certainly not profound.

Before I talk to the class, however, I would like to address a few words to some of the other principals in these exercises.

First, to the administration and faculty of the College of Medicine: For you this graduation is the tangible result of the years of planning and effort that went into the establishment of this fine new medical school. Here is the fifth class to complete its medical education at the University of South Florida. The Class of 1978, like its predecessors, is in a very real sense a measure of what you have done as teachers, advisors and role models to help these young men and women become physicians. If they ultimately become good physicians you are entitled to a share of the credit, just as you must share part of the responsibility for their professional shortcomings.

I do not wish to imply that medical students have no responsibility for their own education. They obviously do, and that will be the theme of what I want to say to the graduating class. But it would be a mistake for you to underestimate the influence a faculty has on the future professional behavior of its students. The total experience of medical school, in all of its intellectual and emotional dimensions, has a tremendous impact on the development of the young physician, and you have a large share of responsibility for the quality of that experience. So the Class of 1978 in a way represents you, and this commencement today is in part yours as well as theirs.

For the families of the graduating class, this is a time for unalloyed rejoicing. You should be very proud but you also must be relieved: proud that your sons and daughters have achieved a long-cherished ambition and highly-prized goal, but also relieved that they will at last soon be self-supporting! I think I know how you feel. I have a son who has finished his first year of medical school and I can hardly wait until he makes it through the next three. So I share your pride, and your relief, and I congratulate you on your good fortune in having at least one offspring who should be able to help you in your old age.

But commencement speeches are not for faculty or families, however much they share in the meaning of the occasion. I should be addressing the graduating class, and that is what I propose to do for the next few minutes.

If you are like all the other brand-new physicians I have known, you are by now disciplined and passably knowledgeable in the ways of medicine and yet still enthusiastic about learning more. The first thing I want to tell you, therefore, is to stay that way. Don't ever lose your zest for learning.

You must have memorized many facts in medical school, but that is not the kind of learning I mean. At the beginning you had to be initiated into the mysteries of the human body, as a kind of rite of passage. That required mastery of a new language and the rapid acquisition of seemingly endless facts and new concepts, most densely packed between the covers of heavy, expensive textbooks. But what you should have tumbled to by now is the most important fact of all — namely that many of these "facts" are destined to change. Textbooks contain

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This address was delivered before the graduating class of the University of South Florida College of Medicine at Tampa, June 17, 1978.

Dr. Relman is Editor of the New England Journal of Medicine and Professor of Medicine at Harvard Medical School, Boston.

few eternal truths. For the most part they simply summarize the current state of the art, which is continually evolving under the impact of research and new clinical experience.

The rate of this evolution can be judged from the speed with which most current textbooks become outdated. With the possible exception of treatises on anatomy, most of them have a life span of five to ten years — some even less. Some fields are changing so rapidly that textbooks are simply not practical; they become obsolete during the time it takes to write and publish them.

Good physicians must learn to cope with this process of constant change. If you want to avoid the fate of those rapidly aging textbooks of yours, you will need to acquire life-long habits of self-education that will keep you in touch with developing knowledge and aware of existing limitations.

How does one do that?

You can, of course, simply throw away your textbooks every five or ten years and buy new ones. Provided that you read the books this would not be such a bad idea but it would not be likely to solve your problem. Textbooks are useful reference sources but they are too slow to change, too lacking in specific detail and often too elementary to satisfy all your future educational needs.

What about postgraduate courses? Nowadays medical educators and all kinds of professional organizations are much interested in what is called "CME," continuing medical education. Recognizing the increasing need for physicians to keep up with new developments, the AMA and many other groups have begun to formalize requirements for CME credits, that is, for attendance at a certain number of lectures or teaching exercises each year. Many state medical societies, for example, are making the renewal of licensure contingent upon the achievement of CME credits, and similar kinds of requirements have been adopted or are under consideration by various specialty boards.

In my opinion CME is fine in principle if it is regarded as one means for physicians to voluntarily further their own education. But if it is to be used as a compulsory legal device to assure the maintenance of professional standards, it will be a snare and a delusion — at least as presently conceived. Physicians need only attend lectures for CME credits. That says virtually nothing about what they learn and even less about their competence.

By this time you will have divined the next suggestion I wish to make: The best way to stay current is to read the medical literature. Since there are about 2500 journals listed in the Index Medicus and probably a nearly equal number of other periodicals that do not get into the Index, one obviously needs to be selective. Many of these journals are, of course, in foreign languages. While not wishing to be chauvinistic or to slight the many excellent publications in other languages, I think it is fair to say that there is no practical need for American clinicians to look beyond the English-language literature. English has become the international language of Western medicine, and almost everything you will ever need to know will be published in English-language journals.

The selection of journals can be made easier by a consideration of the various kinds of publications that are written for physicians. There are, first of all, the medical newspapers. They are, for the most part, "throw-aways," that is, they are distributed free to physicians and depend entirely on advertising for their support. These journals, like other newspapers, carry news items, features, brief summaries of papers presented at meetings and so forth. They may be worth reading for their general interest, but they are not sufficiently detailed or critical to be regarded as primary sources of information.

Another variety of "throw-away" literature is the glossy "educational" journal that contains reviews of current clinical practice and features other types of didactic articles. This is a particularly seductive kind of publication because not infrequently one can find therein gems of exposition, written by well-known authorities, and illustrated beautifully. These journals may have the appeal of the slick mass-circulation magazines but their temptations should be sampled sparingly lest one end up spending too much time on derivative, predigested information which is not always critically selected or reviewed.

Then there are a host of official house organs which are intended mainly to serve the members of the sponsoring society or institution. Original articles are rare in most of these journals and nonmembers are not likely to find much of interest. However, they vary widely in quality. A few are carefully edited and worth general attention but most can be safely ignored.

In my view, you can find virtually everything you need in the clinical literature by confining your attention to a select group of perhaps 200-250 English-language journals. They include journals that publish original scientific articles as well as some that also publish reviews and articles of commentary. Most are devoted to a particular clinical specialty or special field of interest but some are more general and cover all aspects of medicine. What they have in common and what makes them noteworthy is that they publish articles that have been critically reviewed, selected and edited for quality and originality. These are the most reputable and widely known journals in their respective fields. For the most

part, they depend on peer review for selection of their material, and as a group their contents represent the main stream of new primary information that is generated by medical progress.

Obviously no one can read them all, nor is that necessary. You can keep in touch with the broader aspects of clinical medicine simply by reading one or two "general" journals which publish original articles covering all fields as well as commentaries and reviews. In addition you will need to follow the literature of your own special field, whatever that may be. The periodical literature varies widely in quantity and quality in different fields but in most cases you can keep up to date by the careful perusal of a relatively small group of specialty journals, usually not more than five or six. Of course, in some fields there may well be many more titles to choose from but there is also likely to be much duplication and overlap. If you follow a few good journals faithfully, you are not likely to miss anything important.

Whichever journals you choose, your reading ought to be regular and, above all, critical. Don't confine yourself to abstracts or summaries. Insofar as possible, read the original articles, particularly the methods and results, and get in the habit of trying to draw your own conclusions. Remember that if the information in textbooks is mutable so is the content of journals — even the very best of them. You will need to grow comfortable with the fact that the medical literature is a living, growing thing that thrives on controversy and contradiction and is continually being reshaped through experimentation and experience. Nothing is sacred except perhaps the rules of the game itself which demand open-mindedness, honesty, and the fullest possible presentation of good data, carefully and objectively analyzed.

Your reading should include not only technical scientific articles and reviews but also papers on the broader nontechnical issues related to the practice of medicine. Doctors should not be narrow in their outlook but should view their profession in full perspective in all its social, political, economic and ethical implications. The medical literature, at least some of it, is becoming more aware of these broad questions and there is now much for all of us to learn and think about. The public, quite properly, expects that doctors will be well informed, responsible citizens, not just competent technicians.

Medicine's place in society and its relations with government and with other professional and paraprofessional groups are undergoing critical scrutiny. Changes of all kinds, both scientific and social, are coming faster than ever before. You will practice your profession in social settings and with techniques and concepts hardly envisioned only a short time ago.

There is no way to deal with this change except through a life-long dedication to scholarship and self-education. That is the privilege and the challenge you are accepting today.

● Dr. Relman, 10 Shattuck Street, Boston, Massachusetts 02115.

A Request of Our Readers

From time to time *The Journal* receives requests for certain back issues. We try our best to honor these requests, but for many issues our reserves are down to two or three copies.

So we decided to ask our readers if they have some back issues they are willing to return so that we might share them with those needing them.

We are particularly interested in issues published during the 1950s and in 1960.

If you have some of these numbers you are not using please let us know.

Please contact either Mrs. Louise Rader or Mr. Edward D. Hagan, *The Journal of the Florida Medical Association*, P.O. Box 2411, Jacksonville, Florida 32203, telephone (904) 356-1571.

Some Personal Recollections of Coy Lay

James M. Ingram, M.D.

Coy L. Lay, M.D., Associate Professor of Obstetrics and Gynecology at the University of South Florida College of Medicine, and a member of the founding faculty of this Department, died on January 24, 1978.

His devotion to his family and to his profession as well as his truly international recognition in our specialty are universally appreciated and will not be recounted here. Perhaps a few personal recollections by a long-time, deeply admiring friend might serve as a more fitting tribute from the Department and the College of Medicine to this sensitive and singularly gifted man.

In 1951 while still a Fellow at the Mayo Clinic, Coy came by my office in Tampa, introduced himself, and sought an opinion as to the future of a young gynecologist joining the Watson Clinic. He could not have selected a less qualified advisor. I was a veteran of a full six months in private practice, and the very few items on my office accounting books were still being recorded in red ink. Nevertheless, being both younger and brasher than now, I ventured the opinion that Coy's future in Lakeland appeared bright. That, undoubtedly, was the greatest understatement of my medical career.

Even then, 27 years ago, one could not escape the observation that, beneath Coy's almost overly-modest personality, there was a fertile and agile mind, humming away on a dozen totally varied and equally important projects. It was also apparent that the great supporting and stabilizing force in his life was, and would be, the beautifully featured, quietly composed brunette with the arresting eye-to-eye gaze and the soft accent — his wife Madeline.

It was never difficult to keep track of Coy's activities at a distance of 40 miles between Tampa and Lakeland. If he had one enemy in life, that enemy was the "status quo" in anything. One of his first ventures was the acquisition and use, along with Dr. Herman Watson, of the peritoneoscope, a new-fangled illuminated tube, touted by the internists, designed to visualize the abdominal and pelvic viscera. In spite of all efforts, the instrument proved to be, in Coy's words, "about as successful as the Edsel automobile," which appeared briefly a year or so later. He quickly shelved the peritoneoscope but tenaciously clung to the concept of a telescope that would provide quick and easy visualization of the pelvis.

In this characteristic tactic, Coy displayed perhaps his most invaluable cluster of personal traits. These were the impetus and ability to pioneer in new fields, to accept early reverses and failures as part of the game, to push right on, and equally important, to sprinkle professional vicissitude with an occasional dash of wry humor.

The earliest inkling of the perfection of the fibre-optic light system and its possibilities in the old telescope registered quickly in his mind. He was soon off to Berlin and then to England, observing the use of the earliest models, and bringing them back to Lakeland.

Coy had already become an expert laparoscopist by the time that most of us in the country were learning to pronounce the word.

With such a head start in time, he was among the first to realize that the great limiting factor of laparoscopic surgery would be that of electrical burn injuries. His attention immediately focused on this area, but more about that later.

He was equally as adept at both theoretic and practical matters. On the practical side, he perceived the need in obstetrics and gynecology for a direct, rapid, physician-to-physician communication on everyday problems of the specialty. This gradually evolved into the concept of a scientific letter, consisting of various medical questions, answered by "experts" in a particular area, and circulated to subscribers every two weeks or so.

This time he was smart enough not to ask my advice. Instead, he drove over to our home one evening and suggested that I act as intermediary between him and my former chief at Duke, Bayard Carter, to make inquiry if such a periodical would be useful. The question was posed to Dr. Carter by letter and the immediate response was the usual loquacious, four-line, one-third page Carterian classic: "Make it clinical, make it practical, make it brief; and for God's sake, use proper grammar, spelling and syntax. It will succeed."

And succeed it did. Founded in 1960, the Collected Letters of the International Correspondence Society of Obstetricians and Gynecologists are now received by over 4,000 members in 30 countries. Among residents in training, the Letters are one of the most frequently read periodicals. What greater tribute to Coy?

A few years later, in late 1969, the College of Medicine at the University of South Florida began its

development under the leadership of Dean Donn Smith. The Department of Obstetrics and Gynecology was activated January 1, 1971. Shortly thereafter, Coy expressed an interest in "helping out" in some way. Typically, his approach was ultra low-key, almost circuitious. It finally became evident that he was interested in doing more than serving on the Clinical Faculty. He wanted to make a firm commitment to work during a portion of each week. With his inherent ability, plus his national stature in the Fertility Society and other organizations, such a proposal, in a Department struggling to get off the ground, was somewhat overwhelming. Thus, he became both an Associate Professor and a founding member of the Department.

By this time, he had developed the Silastic bands and the prototype of the Lay Bander, an instrument designed to replace electrocoagulation of the oviducts by laparoscopy. The trial and application of this ingenious tool were the first basic and clinical research undertaken in this Department, and were among the initial investigations of the entire medical school. With the vivarium yet to be built, we located a kennel in the farm country in which to keep a dog colony and Coy set to work with enthusiasm and vigor.

His earliest procedures were heavily influenced by Murphy's Laws, and were somewhat short of perfection. The first dog he banded promptly conceived in both horns of the uterus and became the proud mother of 13 puppies.

As might be expected, the great stabilizer, Madeline came forward and assured Coy (and myself) that these were merely technical problems and that all would be worked out. The recorded clinical data have since proved her to be quite correct. The unrecorded portion of the protocol was the fact that Madeline would not hear of any undue fate for the puppies. None of us will know how many countless hours she spent having them immunized, advertizing them in the Lakeland Ledger and finally finding homes for all. Most important, Coy's optimism and perseverance, with some humor, paid off again. The Bander proved to be efficient in subsequent trials in the dog and then the rhesus monkey. It is now an accepted and widely used instrument.

As a teacher of medicine, Coy truly came into his element. His grasp of the subject matter in the area of fertility was broad, and his ability to communicate what he knew to the students was superb. But, in those Friday morning sessions, the students found much more. They saw, in this quiet, compassionate, sensitive, sometimes almost fragile man, most of the intangible qualities that must be added to medical knowledge to create what Osler called "the true physician." In the new and occasionally overly-democratic academic world in which students sometimes grade teachers more often than vice versa, Coy faired well. The vast majority of the grades he earned were the highest, 5, (outstanding — excellent).

His departmental activities were never limited to simply teaching. He was deeply aware of the personal bonds and of the academic and social functions that make a Department more than just a collection of students, residents, and faculty. In spite of the 80 mile round-trip, the Lays were never known to miss a departmental social gathering or to be absent from the sentimental and important days and nights of Resident's Week in June. He was the Department's most generous benefactor, always returning his academic salary and frequently forwarding gifts and contributions from grateful patients.

A devout Methodist and student of religion, Coy was no stranger to the scriptures. He read and occasionally quoted the second great Christian Commandment, "Thou shall love thy neighbor as theyself." The course of his life was so dominated by the love of his neighbor that he sometimes forgot to love himself quite enough. The many of us who loved him simply understood and respected this facet of his nature. Even his few frailties were admirable.

We would do naught but to mourn his loss. Yet, there is solace in a single question. How many of us have done so much for others in so little time?

● Dr. Ingram, Department of Obstetrics and Gynecology, Medical Center, University of South Florida, Tampa 33612.

Cracker Cures

NOSE BLEED

Hold hands over the head with the head tilted backward and chew gum. (if no gum, chew paper).

Reprinted by permission from "Cracker Cures," a publication by the Peace River Valley Historical Society. Edited by Cedric Stephen Wood, P.E. These cures have been collected over the years by friends and members of the Peace River Valley Historical Society and presented a few at a time at each of their regular meetings by Dr. Gordon H. McSwain, custodian.

Estate Planning For Professionals

James A. Urban

Abstract: In this article the author discusses estate planning techniques designed to effect tax savings for persons engaged in professional practice. Federal income, estate and gift taxes are considered. The benefits of practice in the corporate form as a professional association are reviewed, including pension and profit sharing plans, life insurance, wage continuation plans, medical reimbursement plans and buy-sell agreements. The author describes various aspects of lifetime giving and testamentary transfers with emphasis on the changes in estate and gift taxation made by the Tax Reform Act of 1976.

The professional practice is characterized by several attributes which require the application of estate planning considerations differing somewhat from the estate planning opportunities available to those engaged in commercial, as distinguished from professional, business activities. Yet, certain techniques are equally applicable to both. This article will explore certain methods which may be utilized by a person engaged in professional practice to achieve significant estate planning objectives and substantial tax savings. The topic is so broad and the material so complex that volumes have been devoted to the subject. Space limitations preclude any indepth discussion, and this article is necessarily limited to an overview of the subject.

Perhaps the single most important tool available in estate and tax planning for a professional is the utilization of the corporate form of doing business. The professional association, or P.A., has been authorized by statute in Florida since 1961.

James A. Urban has been a practicing attorney in Orlando since 1953. He is a graduate of Duke University (A.B., 1950) and the University of Florida (J.D. With High Honors, 1953). He served as president of The Florida Bar in 1974-1975 and is currently president of The Florida Bar Foundation, Inc. He is a member of the House of Delegates of the American Bar Association, member of the American Bar Association Special Committee on Coordination of Federal Judicial Improvements, Fellow of the American Bar Foundation and member of the Committee on Income of Estates and Trusts of the Tax Section of the American Bar Association. He is a Fellow of the American College of Probate Counsel.

Pension and Profit Sharing Plans

Without question, the most significant lifetime estate building technique for the professional person practicing in the corporate form is the qualified pension or profit sharing plan. Such a plan enables a professional person in his high income years, which, of course, are also high tax bracket years, to set aside tax-free what otherwise would be fully taxable ordinary income. The contributions are held in a fund and, while so held, they build up through appreciation in value and earnings, again tax-free. Distribution occurs at a time when the professional's earned income is eliminated or significantly reduced. With a pension plan, there is a required fixed contribution each year. A profit sharing plan, on the other hand is, as the name suggests, tied to years in which there is a profit, and the contributions can fluctuate from year to year so long as they are recurring and substantial.

The Employee Retirement Income Security Act of 1974 (ERISA) established overall limitations on deductible contributions to such plans, but the limitations are not unduly restrictive. For a pension plan, the deductible contribution is that amount actuarially required to fund the projected pension on retirement, with an overall limitation of the lesser of $75,000 or 100% of the average of the participant's highest three years of compensation. For a profit sharing plan, the deductible contribution is limited to 15% of compensation with an overall annual limitation of the lesser of $25,000 (as adjusted annually by the Secretary of the Treasury for increases in the cost of living) or 25% of compensation. A corporation may have both a pension and a profit sharing plan, with a combined overall limitation. Subject to those limitations, amounts contributed to a plan by a P.A. are deductible by it in computing its income tax. The plan is thereby funded with pre-tax dollars. Moreover, income generated by plan assets is not taxed, so that dollars which otherwise would be paid out as tax on income are permitted to remain in the plan where they continue to earn additional income.

Favorable tax treatment is accorded to payouts. On retirement, that portion of a lump sum distribution allocable to pre-1974 participation in the plan receives long-term capital gains treatment. Although the balance is taxed as ordinary income, it is subject to a special ten year forward averaging computation, provided the

taxpayer was an active participant in the plan for at least five years prior to distribution. The participant can, by electing annuity payments, have those payments taxed in accordance with the general annuity taxation rules, so that the recipient is not taxed on that portion of the payment which represents his investment in an annuity. When the payout is in the form of death benefits, payment is exempt from federal estate tax if payable, other than in a lump sum, to a designated beneficiary other than the personal representative of the estate. Moreover, the first $5,000 in death benefits is excluded from income tax.

Although pension and profit sharing plans are subject to rigid rules and regulations under ERISA, the benefits they can provide are so significant that serious consideration should be given to their establishment by the P.A. Qualified plans can include provisions which permit the use of plan funds allocated to an employee to purchase insurance on his life. This feature can be a valuable benefit to a professional person in his estate planning. Plans may be structured so that a participant may borrow from his vested interest in the trust funds. Although careful drafting of the plan documents and meticulous compliance with the requirements of the plan and applicable law are required, such loans are possible and their availability can be extremely valuable.

Somewhat similar benefits are available to a professional practicing in a noncorporate form, that is, as a sole practitioner or in partnership, through HR-10 plans, but there are significant differences, and annual contributions are subject to different and more restrictive limitations.

Life Insurance

Life insurance is essential in the estate plan of the young professional. Until he has had an opportunity for significant capital accumulation, he can provide adequate income protection for himself and his family only through comprehensive insurance coverage, including disability insurance. For the matured professional, life insurance may not serve the same basic purpose but it remains useful if only to provide funds to pay death taxes. Through proper planning of the ownership of life insurance policies, the proceeds can be totally exempt from estate taxation. An unincorporated practitioner may purchase some life insurance through split funding his HR-10 plan. For the professional practicing in the corporate form, the P.A. can purchase group life insurance up to $50,000 with the premiums, although deductible by the P.A., not being included in income to the benefited employee. Split dollar insurance is also available. Its simplest form involves the purchase of permanent insurance on an employee's life with the employer paying that portion of the premium representing the increase in the cash surrender value of the policy and the employee paying the remainder of the net premium, if any, after dividends. At the employee's death, the employer is entitled to the cash surrender value of the policy and the employee's beneficiary receives the balance of the proceeds. Under this arrangement, however, none of the premiums are deductible, although the premiums may be paid with cheaper dollars due to the lower tax bracket of the P.A. as compared to that of the professional.

Tax shelters, a subject of almost universal interest to professionals, are generally beyond the scope of this article. Although the Tax Reform Act of 1976 greatly reduced the effectiveness of tax shelters, they still have their place in estate planning. A tax shelter of sorts is available to the professional through segregating assets such as professional offices, equipment and the like from the professional practice and holding them in a separate entity. Such assets can be initially acquired by a separate entity or they can be transferred through a sale and lease back or gift and lease back arrangement. Considerable litigation in these areas suggests careful planning to preserve the right to take accelerated depreciation and the right to fully deduct rent paid by the professional to the separate asset-owning entity.

Other Plans

Other estate building opportunities are available to corporate practitioners which are denied to those who practice other than in a P.A. Three such opportunites will be described briefly.

A P.A. may adopt a wage continuation plan to continue the salary of an employee in the event of disability or sickness. If the plan is funded or insured, the corporation may deduct payments made to support the plan and those amounts will not be taxable to the shareholder-employees.

Under a medical reimbursement plan, the corporation can reimburse an employee for medical expenses incurred by the employee and his family. The plan can cover the entire spectrum of medical expenses including such items as contact lenses and orthodontia. Payments are not taxable to the employee but are deductible by the corporation. Such a plan is more advantageous to most professional employees than is the medical deduction allowed on the individual income tax return because of the percentage limitations there applicable. The medical reimbursement plan can be a particularly favorable fringe benefit inasmuch as discrimination in benefits in favor of higher paid employees is permitted. In addition, it is not required that all employees be covered under the plan, the primary requirement being that the plan not be limited to shareholders. If the plan is so limited, payments under

the plan will be treated as dividends to the shareholders.

A corporate employer may pay a death benefit up to $5,000 tax free to the widow or beneficiaries of a deceased employee and the amount so paid may be deductible as an ordinary and necessary business expense of the corporation.

The professional's estate plan requires that there be an arrangement for the transfer of his professional interest in the event of his death, disability or retirement from active practice. At least for the professional practicing in a partnership or a P.A., it is essential that there be a buy-out agreement to effect a smooth transition of ownership. The terms of the buy-sell agreement are extremely important and deserve careful attention. Of equal importance is the funding of the buy-out arrangement so that it provides a viable vehicle to assure payment to the retiring professional, or to his family in the event of his death, without imposing severe financial burdens on the continuing professional entity. Methods are available by which the problem can be resolved if appropriate attention is timely devoted to its resolution.

Finally, the professional person, like everyone else, needs a personal estate plan, which includes at least a will. His estate plan may also involve a program of lifetime giving and perhaps a living trust.

On October 4, 1976, President Ford signed into law the Tax Reform Act of 1976 (TRA '76) generally applicable in the gift tax area as to gifts made on and after January 1, 1977, and in the estate tax area as to decedents dying on and after that date. TRA '76 is perhaps the most extensive single revision of the tax laws of the United States ever undertaken by Congress, especially in the areas of estate and gift taxation.

Lifetime Giving

One of the purposes of Congress in enacting TRA '76 was to minimize the tax savings available by the reduction of one's estate through lifetime giving, thus reducing the total tax burden on gratuitous transfers during life and at death. This congressional objective was accomplished by two significant changes in the law. First, a single unified rate schedule was substituted for the former separate gift tax and estate tax, under which gift tax rates were invariably equal to 75% of estate tax rates. Thus, the former gift tax rates, which began at 2¼% for taxable net gifts up to $5,000 and increased to 57¾% for taxable net gifts over $10 million, and former estate tax rates, which began at 3% for net taxable estates up to $5,000 and increased to 77% for net taxable estates over $10 million, have been replaced by a single unified rate, beginning at 18% for taxable transfers up to $10,000 and increasing to 70% for taxable transfers over $5 million. Secondly, a single unified credit has replaced the former lifetime gift tax exemption of $30,000 and the former estate tax exemption of $60,000. The unified credit is applied during lifetime to offset any gift tax otherwise due on inter vivos transfers and, to the extent not used up to offset gift taxes, is available as a credit against the estate tax imposed on transfers at death. Nevertheless, lifetime gifts continue to provide a significant estate planning tool through which substantial tax savings can be achieved.

Although the $30,000 lifetime gift tax exemption was eliminated, the $3,000 annual exclusion has been retained. That exclusion permits a donor to give $3,000 per year, each and every year, per donee, to as many donees as he chooses, without incurring any gift tax. Gift splitting permits a married donor to double that amount if the donor's spouse consents to have half the gift treated as though made by the spouse. To illustrate, a married couple with three married children, each of whom has two children, can give to their children, their children's spouses and their grandchildren $72,000 tax free each year. A continuing program of such gifts over a number of years can provide dramatic tax savings, without using up any of the unified credit.

The annual exclusion has taken on added significance because of the change in the law made by TRA '76 as to gifts made within three years of death. Formerly, such gifts were presumed to have been made in contemplation of death and the amount of such gifts, unless the presumption was overcome, was brought back into the decedent's estate and taxed there. TRA '76 eliminated the contemplation presumption. Instead, all gifts made within three years of death, irrespective of the motive, are brought back into the decedent's estate and taxed at his death — all gifts made within three years of death, that is, except annual exclusion gifts. Those gifts are not brought back into the decedent's estate. They escape taxation even if made on one's deathbed with knowledge that death is imminent and with tax avoidance as the only motivation. The amount of a split gift attributed to a consenting spouse, made within three years of the death of the donor, is included in the decedent's estate.

In order to qualify for the annual exclusion, a gift must be of a present interest. An outright gift of an asset having a present value, say cash, is the clearest example of a present interest gift. The fullest utilization of the annual exclusion, however, will usually involve gifts to children and grandchildren, who may be minors. Outright gifts to minors are seldom advisable. Gifts to custodians under the Uniform Gifts to Minors Act will qualify, assuming the asset given has a present value. Gifts made in trust for the benefit of minors may also qualify for the annual exclusion, provided the terms of the trust meet the rather stringent distribution

requirements of the Internal Revenue Code. Failure to meet the Code requirements will cause the annual exclusion to be lost.

Even gifts having a value in excess of the annual exclusion can provide tax savings. This seeming anomaly, in view of the single unified rate and the single unified credit for inter vivos and testamentary giving, is possible because, assuming the donor lives three years, all appreciation in value occurring subsequent to the gift is removed from the donor's estate. Additionally, the unified credit makes a difference. So much more can now be given away than before without paying any gift tax. Prior to TRA '76, each person had a lifetime gift tax exemption of $30,000. That is, apart from the $3,000 annual exclusion, the first $30,000 given away during lifetime was not subject to gift tax. That exemption has been replaced by a unified credit offsetting the tax. The credit is phased in over a five year period. For 1978, the credit is $34,000, but that is equivalent to an exemption of $134,000 and in 1981 the credit will have increased to its maximum, $47,000, equivalent to an exemption of approximately $175,000. An example may be helpful. Assume a married donor this year makes a gift of property having a value of $140,000. No tax will be payable at the time the gift is made. The annual split gift exclusion of $6,000 will reduce the value of the gift to $134,000 on which the tax is $34,000, and that is totally offset by the unified credit. If the property doubles in value in ten years, after which the donor dies, the donor will have effectively passed the appreciation of $140,000 tax-free. If the donor lives 20 years, assuming a second doubling in value in the second ten years, the amount of appreciation passed tax-free increases to $420,000. By 1981, a gift of $181,000 may be made tax-free. Assuming again a similar doubling in value, the amount of appreciation which can be passed tax-free, if the donor lives 20 years, increases dramatically to $543,000.

Not only is the appreciation in value passed tax-free, but a further tax savings is achieved because the appreciated value will not be a factor in the determination of the estate tax bracket for property remaining in the donor's estate at the time of his death. Inasmuch as the tax is graduated, the larger the estate, the higher the bracket. Although the minimum estate tax rate is 18%, the minimum effective estate tax rate is 32%, which is the rate applicable after applying the credit. Thus, the "removal" of appreciation from estate taxation is extremely significant. Further, even if the value of the gift is such that the gift tax attributable to it exceeds the credit, the gift tax payable at the time of making the gift, other than gift taxes paid on gifts made within three years of death, is removed from the donor's gross estate. Further, income which the gifted property generates subsequent to the gift, which might otherwise be accumulated in the donor's estate, thereby escapes being taxed at his death in his estate. Moreover, assuming that the donee is, as will usually be the case, in a lower income tax bracket than is the donor, the income generated by the gifted property will be taxed for income tax purposes at the donee's lower bracket. Finally, the subsequent sale of the gifted property may cause it to be taxed at a lower capital gains rate than if it had been retained by the donor and then sold by him. The maximum capital gains rate is no longer the magic 25% once universally applied. For an individual in the top 70% bracket who has gains in excess of $50,000 and who is subject to the 15% minimum tax on tax preferences, the effective capital gains rate can be as high as 49.125%.

The benefit available to a high income tax bracket taxpayer who makes a gift of income producing property to a donee in a lower income tax bracket thereby reducing the income tax impact can also be achieved without the necessity of making a completed gift if, for some reason, the donor wishes to retain ownership of the property but, at the same time, have the income taxed to a lower bracket taxpayer. This can be accomplished through use of the so-called Clifford trust under which income producing property is transferred into a trust which is to last at least ten years, after which the corpus reverts to the grantor or another person designated by the grantor. The Clifford trust, sometimes called a short-term trust or a ten year trust, is an especially useful device to provide funds for the education of a child. The trustee, who is given discretion to distribute income for the benefit of the child, typically accumulates the income and expends it for post-high school education. Unless the income is currently expended for the support or maintenance of a child whom the grantor is legally obligated to support, the income should not be taxed to the grantor. The income is, of course, taxed to the child, but only to the extent that it exceeds his personal exemption and then at the child's lower rate, or to the trust, which also has an exemption, at the trust's lower rate. The Clifford trust can also be utilized effectively to provide income to a parent or other relative in need of support. It has been suggested that TRA '76 sounded the death knell for Clifford trusts. This conclusion is based on the fact that when the gift in trust is made, the gift tax attributable to the value of the gifted property, to the extent it exceeds the annual $3,000 exclusion, reduces the unified credit but, when the trust corpus reverts to the grantor after ten years, the used up credit is not restored. Although this is true, the report of the demise of the Clifford trust is, as Mark Twain said when told of the report of his death in the obituaries in the newspaper, greatly exaggerated. First, the transfer is not measured for tax purposes by the fair market value of the assets

transferred, but only by the present value of the 10 year income interest, which is slightly less than 45% of the value of the gifted property, so that the trust may be funded by annual gifts within the $3,000 annual exclusion. Inasmuch as the annual exclusion is per donee, a donor can create multiple short term trusts, limited only by the number of donees whom he wishes to benefit, and he can add to them in subsequent years so long as the term of the trust is more than 10 years when additions are made.

An alternative to the Clifford trust is the interest-free loan between family members. Typically a family member in a higher income tax bracket, say a parent, loans money to a trust for the benefit of a child and receives demand notes providing for no interest prior to demand. The money loaned is then invested in an interest-bearing bank account. The interest is taxed to the lower bracket child and there is no income to the higher bracket parent. The net income tax effect of the transaction is identical to a Clifford trust but, unlike the Clifford trust, the transfer is not subject to gift tax liability and can exceed the amount of the annual exclusion without using up any of the unified credit. Although the Internal Revenue Service takes the position that an interest-free loan constitutes a gift by the lender of the value of the use of the money loaned, the United States Tax Court, in a recent case in which the issue was litigated, held that there was no gift. The case is now on appeal.

Transfers at Death

Three significant changes made by TRA '76 affecting transfers at death deserve mention.

The marital deduction, perhaps the single most significant device for the saving of federal estate taxes, was liberalized. Stated in over-simplified terms, the marital deduction permits a married person to leave "tax-free" to his or her surviving spouse an amount equal to 50% of the adjusted gross estate. (The term "tax-free" as used here is a misnomer. The portion of the decedent's estate which qualifies for the marital deduction is not taxed in his or her estate but, to the extent not consumed, is taxed in the estate of the surviving spouse on his or her subsequent death). There are, nevertheless, substantial advantages. Payment of the tax is deferred to the estate of the second spouse to die. In tax planning, it is axiomatic that tax deferral is second only to tax avoidance (not evasion, which is illegal) in effectiveness. Because the estate tax is graduated, the allowance of the deduction in the estate of the first spouse to die causes that estate to be taxed at a lower rate. TRA '76 increased the maximum marital deduction to the greater of 50% of the adjusted gross estate or $250,000. Thus, estates of less than $500,000 are benefited. Prior to TRA '76, a married person could pass an estate of $120,000 tax-free to his or her surviving spouse. One-half the estate, or $60,000, qualified for the marital deduction and the $60,000 exemption prevented the imposition of any estate tax on the remaining half. By 1981, when the unified credit is fully phased in, it will be possible for a married person to pass an estate of approximately $425,000 tax-free to his or her surviving spouse. A transfer qualifying for the marital deduction may be outright or in trust but, in order to qualify, the interest must not be a terminable interest, as that term is defined in the Internal Revenue Code, and there must be meticulous compliance with the stringent requirements of the Code.

A second tax reform was achieved by TRA '76 in the form of the so-called orphan's deduction. This entirely new provision of the Internal Revenue Code permits tax-free gifts to minor children left parentless. The amount which may be given tax-free to a minor child (defined as a child who has not attained the age of 21 before the date of the decedent's death) may not exceed an amount equal to $5,000 multiplied by the excess of 21 over the age of the child. Thus, an 11-year-old child can be given $50,000 tax-free. The potential tax savings can be substantial. To illustrate, a decedent leaving three children, ages 10, 12 and 14, could pass to them tax-free an amount totaling $135,000. A widowed parent of children under age 21 should consider including in his or her will appropriate language to take advantage of the orphan's deduction should it become applicable. Even if both parents are living, the possibility of simultaneous death should be anticipated. As in the case of the marital deduction, an outright gift will qualify, but minor children are seldom suitable recipients of outright gifts. Gifts in trust should be utilized but, in order to qualify such gifts, there must be strict compliance with the requirements of the Internal Revenue Code.

Finally, TRA '76 eliminated the long-standing income tax rule that the basis of a decedent's property is "stepped up" to his date of death (or alternate valuation date) value, thereby permitting appreciation in value of the property during lifetime to escape capital gains tax when sold by the estate or beneficiaries. Instead, the decedent's basis in the property is carried over to the estate and beneficiaries. For determining gain, there is the fresh start provision under which the basis of property is stepped up to its fair market value on December 31, 1976, so that appreciation in value occurring before 1977 is not subject to the carry-over basis rule. Much appreciation in value of assets acquired from a decedent, which previously escaped taxation upon the sale of those assets, will now be taxed. Furthermore, the allocation of assets distributed in kind

out of an estate among multiple beneficiaries can now be very important. That is, it may be desirable, at least tax-wise, to allocate high basis assets to one beneficiary and low basis assets to another. Without specific authorization in the will to do so, however, the personal representative of the estate may be required to allocate assets pro-rata and if, by agreement of the beneficiaries, he makes a non pro-rata distribution, each beneficiary will be considered to have constructively received his pro-rata share of each asset and then to have exchanged his share for another share, producing taxable gain. This adverse consequence can be avoided by giving the personal representative the power to make non pro-rata distributions. Yet, most wills prepared before TRA '76 and some prepared after TRA '76, without sufficient attention having been given to that comprehensive act, may not contain such a power.

Carry-Over Basis Rule

The new carry-over basis rule has broader overtones. This article discusses — in barest outline — just two which may be of interest.

Section 303 of the Internal Revenue Code accords favorable tax treatment to the redemption by a corporation of stock owned by a decedent to provide funds to pay estate taxes and certain expenses of the administration of his estate. It does this by allowing less than all the decedent's stock to be redeemed without the proceeds being treated as a dividend. When that stock took a date of death stepped up basis, no gain was realized on its redemption at that value. The new carry-over basis restricts the utilization of 303 redemptions. Although 303 redemptions are not suitable for the redemption of P.A. stock (because of restrictions on permissible stockholders), many professionals have interests in outside business ventures and those interests will likely be in the form of stock ownership in a closely held corporation. In such situations, a 303 redemption can be a most useful vehicle to achieve estate liquidity. TRA '76 suggests a close look at such situations and a careful review of applicable documents.

The carry-over basis provision of TRA '76 also affects buy-sell agreements funded with life insurance, a device commonly utilized by a P.A. Under a typical stock redemption agreement, the corporation owns the policies. Upon redemption of the stock of a deceased shareholder, the basis of the stock owned by the surviving shareholders remains the same while their respective ownership interests increase. On the other hand, if a cross-purchase agreement is used, under which each shareholder owns policies of insurance on the lives of the other shareholders, the surviving shareholders obtain a new basis in the purchased shares, that being the purchase price. The choice between these two classic formats, therefore, has tax consequences and should be carefully considered.

Conclusion

At the outset it was noted that this article would necessarily, because of space limitations, provide only an overview of a broad and complex subject. In conclusion, it should be observed that no two situations involve precisely the same facts and the generalized statements made in this article can be applied only after careful and thorough review of each individual's circumstances. Effective implementation of the concepts discussed in this article requires the services of competent professionals trained and experienced in the fields of estate planning and taxation.

● Mr. Urban, 25 West Church Street, Orlando 32801.

Cracker Cures

MORNING SICKNESS

To stop morning sickness, drop a bunch of cold keys down the neck.

Reprinted by permission from "Cracker Cures," a publication by the Peace River Valley Historical Society. Edited by Cedric Stephen Wood, P.E. These cures have been collected over the years by friends and members of the Peace River Valley Historical Society and presented a few at a time at each of their regular meetings by Dr. Gordon H. McSwain, custodian.

Separate Department of Health On November Ballot

With the November election a few days away, the Florida Medical Association is intensifying its efforts to assure Florida a strong public health program administered by a separate Department of Health.

FMA invited county medical society and specialty group presidents, and officials of allied health professions and voluntary health agencies to a meeting last month at Lake Buena Vista to solidify public support for Constitution Revision #1.

Revision #1 is one of eight constitution revisions on which Florida voters will have a chance to express themselves in the November 7 election. It is by far the longest revision, covers a wide range of constitutional matters in addition to providing for a separate Department of Health, and will be described on the ballot simply as:

"Proposing a revision of the Florida Constitution, generally described as the Basic Document, embracing the subject matter of Articles I (Declaration of Rights), II (General Provisions), III (Legislature), IV (Executive), V (Judiciary), VI (Suffrage and Elections), VIII (Local Government), X (Miscellaneous), XI (Amendments) and XII (Schedule), except for other revisions separately submitted for a vote on this ballot."

If voters adopt Revision #1, the following language will be added to the Florida Constitution:

"Department of Health. — There shall be a department of health, the head of which shall be a physician with training in public health who is appointed by the governor and confirmed by the senate. The department shall have supervision of matters pertaining to the protection and promotion of the health of the people of Florida as prescribed by law.

"This section shall take effect on July 1, 1979."

The potpourri of constitutional matters embraced by Revision #1 also includes elevating to constitutional status the open meetings and public records laws; changing the starting date for annual sessions of the Legislature from April to February; and extending homestead exemption to mobile homes.

The November 7 election will culminate many months of effort by Florida's Constitution Revision Commission. The group included Edward R. Annis, M.D., of Miami, and Marcelino Oliva, D.O.

For the last decade the Florida Medical Association has been fighting for a separate health department for the people of Florida. Until 1968, an effective public health program was administered for many years by the State Board of Health and a State Health Officer.

However, the 1968 constitution gave birth to the massive and cumbersome Department of Health and Rehabilitative Services, which numbered among its operating branches a State Division of Health. From there on, public health in Florida began withering on the vine.

A few years ago, the legislature responded with firm resolve to the Department of HRS's demonstrated inefficiency by wiping out all the divisions, including health, and consolidating all departmental programs under 11 district czars.

The state health officer was rechristened the "staff director of the health program office" and his slot on the Department's organizational diagram was dropped several spaces.

In the November election, the people of Florida have another chance to make their public health program one of which they can be proud.

I do not like the phrase: never cross a bridge until you come to it. The world is owned by men who cross bridges in their imaginations miles and miles in advance of the procession.

Bruce Barton



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN®
(ISOXSUPRINE HCl)
20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

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This asthmatic isn't worried about his next breath...

he's active he's effectively maintained on

QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%



- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphtol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

See package insert for complete prescribing information.

Mead Johnson PHARMACEUTICAL DIVISION

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EDITORIALS

Medical Press-Agentry

Advertising is a form of paid, public announcement, intended to promote the sale of a commodity or service, and essentially a form of communication. To the manufacturer, advertising is part of the firm's marketing program. To the various media of communication, it is a major source of revenue; to the consumer, it is a source of information regarding products and services.

The first advertising was by public criers who, in ancient times, walking through the streets, called attention to the sale of such items as slaves, cattle and imports. The development of printing made it possible to markedly enlarge the number of potential buyers. Progressing to radio made available the entire world as a common market. Now television, in the last three decades, is a media whose entire revenue is drawn from advertising. Does it not then appear ironical that today's fake world of TV entertainment, its hedonism, its celebration of instant satisfaction and emotional dependency, is directly undermining the disciplines, virtues and habits of soul on which the capitalistic ethic depends?

In the United States, Ben Franklin is regarded as the father of advertising for he put ads before editorial matter in the masthead of the Pennsylvania Gazette in 1729. Then in the 19th century, there began a period of expansion in advertising as well as in business generally, and following World War I, an era of salesmanship developed with advertising accepted as an essential tool. "It pays to advertise" became a standard slogan. Today, advertising's chief contribution is considered to be its ability to promote a dynamic expanding economy. Some evidence suggests that advertising makes things cheaper. Since the price of a product is based on the cost of marketing and the demand for it, so an increase in demand should increase the production of any commodity. It should then be possible to reduce the cost per unit significantly if the volume continues to increase and bring about a lower cost per unit. Yet the evidence is sketchy in the roll of advertising and too complicated to make generalizations regarding the ultimate effects of advertising on price. Transposing this to the practice of medicine and individual care of patients makes one further question its validity. Advertising, when widely used, can act as a stimulant when sales are difficult to get, but has been accused of causing a monopoly and a decrease in the number of choices open to the consumer.

Will advertising by physicians, strong advocates of private enterprise and individual initiative, become a reality in the United States? Advertising, long viewed as unethical by the medical profession, is opposed by most physicians, but last June the U.S. Supreme Court ruled that it was unconstitutional for professional societies to bar members from advertising. That decision dealt with an Arizona lawyer. Despite that decision, in the ensuing year, only 3% of lawyers took such an opportunity while 89% of those polled said they had no plans to advertise.

More recently, the Federal Trade Commission, in an anti-trust suit against the AMA, alleges that competition is stifled by keeping practitioners from advertising, for "doctoring is a business" according to the FTC, "and physicians should vie for patients by lowering fees and becoming more competitive." Such soliciting, however, could be contrary to professional principles. If patients are approached with cheaper promises of treatment, this could create a demand for more services. Consequently, each competitive doctor will have to see more and more patients, giving less time to each individual patient and adversely affecting the quality of medical care.

Medical advertising is not new. In England in *The Tattler*, September 14, 1710, there appeared the following; "If a man has pains in his head, cholic in his bowels or spots in his cloathes, he may here meet with proper cures and remedies." While much of the early newspaper advertising in the colonies was for patent

medicine whose unpredictable results gave advertising a bad name, the present attempts of the Federal Trade Commission suggests that they are trying to make it appear that doctors are more interested in profits than healing, and so turn a profession into a trade.

If medicine were a business, and health a marketable item, then it would be a logical step to apply the principles of business to the "health care" industry. What, however, does one do about those poor quality items that roll off the "assembly line" such as birth defects, unavoidable complications, old age, and death; for it is obvious that good health cannot be guaranteed or controlled.

Extravagant claims of cures in medical ads will play on the fears and vanities of the public and could send patients to doctors hoping for results or cures that are not always possible to produce. Advertising by an oncologist could promote anxieties about cancer. Psychological depression could follow the plastic surgeon's ads for youthful looks through hair transplants, face lifts and breast augmentation, when the patient, following treatment, realizes that he or she doesn't feel as young as he or she looks. Is the philosophy of the market place what the public wants taught to the young idealistic medical student hoping to enter the profession to serve mankind? Or would the public, enticed into health care mills by medical advertising, care to be treated by the M.D. director who spends more of his time striving to seeing more patients to lower cost by increasing production?

A doctor's first concern is to help his patient, and to do this adequately, there must be a good patient-physician relationship. For this, it is necessary that the doctor be trusted by his patients as this is the invisible glue that binds them together. But somewhere or sometime a gap may develop between the patient and his doctor, which could happen should the doctor's profit motive take precedence over his service. Trust is not required in a business transaction — only results. If the results are as bad as inevitably sometimes happens, a lawyer may step into the gap and the patient sues. So, one cause of a professional-liability suit can spring from the delusion that medicine is a business. Remindful of the "quacks" of years ago and the patent medicine men with their spooky snake oil cures, competitive advertising among the health professions could build professional jealousy, unhappy rivalry and name calling, all leading to splintering of the medical community's mutual assistance and trust, so helpful when more than one M.D. is involved in treating a critically ill patient.

A more worthy purpose of advertising is **to inform,** for information to the laity about doctors has not always been easy to obtain. Only in recent years have listings of specialists appeared in the yellow pages of the telephone book. Even here, the doctor is being exploited to list himself in as many places as possible. Some consumer organizations are doing a more accurate job of compiling medical directories listing types of specialties, fees, and hospital affiliations. Cooperation from medical societies with truthful statements would give patients more information,* especially if there were regulations to prevent misleading information.

It is unlikely that competition will really drive down doctors' fees, for what patient will bother finding one doctor whose fees are less than another, when an insurance company or the federal government is paying the bill? Then too, many people relate price to quality and so look for a doctor who is more expensive because they believe that he must be better. Factually, however, patients seek the opinion of their neighbors and friends in looking for a doctor. Invariably the doctor's availability, gentleness, success in treating others, and compassion are all considered; qualities that are difficult to enumerate or justify in an ad. Unfortunately, a charlatan with a Madison Avenue agency, a glib tongue, and a production-line office may rapidly develop a practice, and dupe many people without having the essential qualities of a dedicated physician. This is what we abhor. This is the danger of advertising. This is what we must convey to the public.

C. M. C.

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*See page 8, American Medical News, Oct. 6, 1978.

Another Thought

The preceding editorial is on a timely subject and the author has covered it well, though not necessarily completely.

There is an area that should be addressed and that is the question: **"How do I as a patient, learn in advance whether the physician I have an appointment with is fully trained, competent, and further does he charge reasonably for his service (or is he an over-priced gouger, or a cut-rate medical vendor?")**

The public really does not know how to get information about their doctor and indeed there are ways of finding out facts regarding a physician's training,

The physician and/or his medical staff should be willing and able to give out factual information upon a patient's request concerning the doctor's medical background, his training, his years of practice and further, the doctor should be willing to answer questions in advance regarding his level and methods of charging, and also whether he takes assignments for indigent, Medicare or Medicaid patients, or whether he does not and whether he has flexibility in his collections methods or not, et cetera.

If the physicians around the country would make such information easily available upon request by a potential patient, then there would be no clamor on the part of the government demanding and perhaps encouraging physicians to advertise in the media. It would do away with most of their arguments.

There is a big difference between **public solicitation** on the part of the doctor and **making available** valuable and perhaps critical information for a patient or his family to use in making their important decisions regarding their care.

Joseph G. Matthews, M.D.
Orlando

Why a Department of Health?

Jesse L. Judelle, M.D.

In this month's general election voters will have the opportunity of revising the Constitution of Florida. Revision number one of the basic document includes a provision that would create a Department of Health. The proposed revision states: "There shall be a Department of Health, the head of which shall be a physician with training in public health who is appointed by the Governor and confirmed by the Senate. The department shall have supervision of matters pertaining to the protection and promotion of the health of the people of Florida as prescribed by law."

Historically, in 1889 a State Board of Health was established in keeping with constitutional provisions of the times. The head of this agency was a physician, and his official title was State Health Officer. During the 80 years of its existence the office developed the county health departments, and worked to control or to eradicate many communicable diseases. The State Board of Health's effectiveness was distinguished by a close, cooperative, relationship with private practitioners as well as various health professionals, voluntary associations, and communities in Florida. Over those 80 years the public and private sector worked together closely. The State Board of Health and the 67 county health departments comprised Florida's public health system and was considered a model for the nation.

However, while the county health departments still exist, the State Board of Health has been eliminated. In 1969, the Department of Health and Rehabilitative Services (HRS) was born as an experiment in government, not in the constitution, but as a result of a legislative enactment. Originally, HRS consisted of 11 divisions: (1) Administrative Services; (2) Corrections; (3) Youth Services; (4) Retardation; (5) Vocational Rehabilitation; (6) Family Services; (7) Health; (8) Planning and Evaluation; (9) Mental Health; (10) Children's Medical Services; and (11) Aging. The Reorganization Act of 1975 passed by the Florida legislature separated the Division of Corrections from HRS, abolished the other 10 divisions, reorganizing them into three major entities within HRS at the State level: (1) Administrative Services; (2) Operations; and (3) Planning. HRS is decentralized by dividing the state into 11 service districts, hoping to bring the management of service operations a little closer to the clients served by the department. In theory, this was to streamline the programs' operations. But, for county health departments, service districts actually interjected another layer of bureaucracy between them and their public health counterpart at the state level.

Somewhere within this mammoth agency remains the vestige of the State Board of Health, now called the Health Program Office. The five physicians, two dentists

and five public health nurses who make up the staff have no direct authority over any of the county health units. They have no authority to implement health plans. They have no direct access to the Governor, or to the Legislature, or to other agencies. They can only make contact with these people when granted permission by their superiors, which is usually done on a restricted basis confining contact to the specific issues and situations.

An example of the problems with the system can be shown in reviewing what happened to the Health Program Office proposals for health priorities in Florida. Legislation on "hypertension" was ranked number two by the Health Program Office, and was ranked number 22 in HRS priorities. Number three, "food inspection," and number four, "Statewide maternal and infant care plan," were not even included in the issues that were going to be taken up by HRS before the Governor and the legislature. Also, some of the obvious public health concerns that have been moved out of the Health Program Office include:

Licensure and Certification
Hospital and Nursing Homes
Home Health Agencies
Swimming Pools
Hearing Aids (Fitting and Selling)
Emergency Medical Personnel and Vehicles
Hospital Plans Review
Drugs and Bedding

Entomology Programs
Mosquito Control
Florida Entomology Laboratory
West Florida Arthropod Laboratory
Dog Fly Control

Vital Statistics
Public Health Statistics
All Laboratory Services
Radiological Health Inspections & Surveillance
Public Health Pharmacy
Community Tuberculosis Control
Tuberculosis Hospital
Emergency Medical Services
Immunization Program
Venereal Disease Control
County Health Department Liaison
Family Planning

It is apparent as we view what has occurred, that Florida's public health program is fragmented, and that it once again needs a coordinated and cohesive plan to re-establish it in the state.

The objective of a Department of Health will be to bring together, in one agency, all of the major health functions that have been fragmented in the current HRS structure. This should include mental health, public health, children's medical services and Medicaid, as well as comprehensive health planning (presently a separate program not associated with health in the present department).

While the major focus of the department will be as an advocate for health programs that effect the entire population, it will also serve as a resource for the health services needed by operating programs within the Social Services Department and other state agencies such as Offender Rehabilitation. Local coordination will insure that health and mental health services needed by clients of the social service department are provided.

Conceptually, Florida's Department of Health will follow the pattern adopted by a majority of other states in the nation, which include many states with populations larger than Florida. Not only will it result in improved health services and planning, but should improve the capability of the state to provide services for the indigent by creating a social services department that can concentrate its talents and resources on this important facet of state government.

From a fiscal standpoint, the new structures will provide manageable entities that can provide needed services more economically. The district system for social services is already in place and can serve as a primary focal point for coordination of efforts between the two departments to meet the needs of Florida's indigent. Another important economy will be the reduction in cost of the bureaucratic superstructure which has been continuously growing in an attempt to cope with the management problems of HRS.

Florida, with a new Department of Health, can move forward in the next decade with the capability to meet the health needs of a growing population. We can truly become a national leader in providing innovative solutions to the critical problems that face all Floridians in this vital part of our daily lives.

● Dr. Judelle, 1330 Miccosukee Road, Tallahassee 32303.

The person who does not read has little advantage over one who can't.

UNIVERSITY OF MAIMI SCHOOL OF MEDICINE—DEPARTMENT OF INTERNAL MEDICINE

FOURTEENTH ANNUAL POSTGRADUATE COURSE

"INTERNAL MEDICINE 1979"

February 11-16, 1979

FONTAINEBLEAU HILTON HOTEL MIAMI BEACH, FLORIDA

Directors: William J. Harrington, M.D. and Eric Reiss, M.D.
Program Coordinator: Jose S. Bocles, M.D.

THE OBJECT OF THIS COURSE, THE FOURTEENTH IN ITS SERIES, IS TO PROVIDE AN ANNUAL UPDATING OF THE MOST USEFUL RECENT ADVANCES IN THE DIAGNOSIS AND MANAGEMENT OF INTERNAL MEDICAL DISORDERS AS THEY ARE ENCOUNTERED BY PRIMARY CARE PHYSICIANS AND PRACTICING SPECIALISTS.

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MEET THE FACULTY SESSIONS
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These sessions will consist of simultaneous group meetings in which illustrated aspects of each subspecialty are presented followed by open discussion. These sessions will be devoted to the presentation of topics in *Critical Care in Internal Medicine.* Special emphasis will be given to the most recent advances in the management of the critically ill patient.

STATE OF THE ART LECTURES
Each subspecialty will be introduced by a State of the Art Lecture given by a distinguished authority.

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Audio visual teaching aids (television sets with tape players, slide projectors synchronized with cassette tapes and guides) will be available during the meeting for self instruction and reinforcement.

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An extensive program will be offered daily.

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The Learning Center consists of video tapes and fully automatic synchronized cassette/slide projection of lectures. This center will be available during the evenings.

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The hotel, presently under complete renovation, has several golf courses with complimentary green fees provided, two swimming pools, private beach ice skating rink, complete gymnasia, bowling lanes, tennis courts, shuffle-board and a billiard room.

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As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that this continuing medical education offering meets the criteria for 35 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed. Approval by the American Academy of Family Physicians for prescribed hours will be applied for.

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REGISTRATION: $350—Physicians $200—*Physicians in training. **For Registration and Information write to:** J. BOCLES, M.D., Department of Medicine, University of Miami School of Medicine, P.O. Box 016760, Miami, Florida 33101, Phone: (305) 547-6063.

*Letter from Chief of Service must accompany registration.

ORGANIZATION

Preliminary Program
Symposium on Nutrition Headlines
105th Annual Meeting Scientific Program

A nutrition program extending over three days has been arranged as the feature attraction of the scientific program for the 1979 Annual Meeting of the Florida Medical Association.

Calvin W. Martin, M.D, of Arcadia, Acting General Chairman for the Scientific Program, said the nutritional aspects of the meeting were arranged by the FMA Ad Hoc Committee on Nutrition, the Florida Society of Clinical Oncologists and the Florida Academy of Family Physicians.

The program will get underway on Wednesday, May 23, at the Diplomat Hotel in Hollywood, with a program co-sponsored by the Clinical Oncologists. There will be a general symposium on Thursday afternoon, May 24, followed by a program arranged by the Florida Academy of Family Physicians on Friday morning, May 25, and a series of workshops that afternoon.

Dr. Martin said several other specialty society program chairmen had completed their section programs, which are published in this issue of *The Journal.* Others will be published as they become available.

Florida's three medical schools — the University of Miami, the University of Florida and the University of South Florida — have agreed to co-sponsor the scientific program, Dr. Martin added, and application will be made to the Medical Education Committee of the Florida Medical Foundation for certification of AMA Category I Credit.

The program, as it stood when this issue of *The Journal* went to press:

SYMPOSIUM ON NUTRITION

(Co-sponsored by FMA Ad Hoc Committee on Nutrition, Florida Society of Clinical Oncologists, and Florida Academy of Family Physicians)

Wednesday, May 23—1:30 p.m. to 4:00 p.m.

"Nutrition and Cancer," Ted Copeland, M.D., Professor of Surgery, University of Texas, Houston, Texas

Other Topics to be Announced

Thursday, May 24—1:30 p.m. to 5:00 p.m.

I. The Art of a Nutritional Diagnosis

"What Nutritional Diagnoses Are You Missing?" George Christakis, M.D., Professor of Nutrition, University of Miami School of Medicine, Miami.

Quiz

II. Clinical Nutrition Problems and What You Tell Your Patients

"Obesity: Medical and Surgical Management," Ted Van Italie, M.D., Professor of Medicine, Columbia University College of Physicians and Surgeons, New York, N.Y.

"Pregnancy," Charles Mahan, M.D., Professor of Obstetrics and Gynecology, University of Florida College of Medicine, Gainesville.

"Hyperlipidemia and Arteriosclerosis: Prevention and Treatment by Nutrition," Sam Hashem, M.D., Professor of Medicine, Columbia University College of Physicians and Surgeons, New York, N.Y.

"Gastrointestinal Disease," James Cerda, M.D., Professor of Medicine, University of Florida College of Medicine, Gainesville.

"Fad Diets," Victor Herbert, M.D., Professor of Medicine, Mount Sinai School of Medicine, New York, N.Y.

III. Questions and Answers

Friday, May 25—8:30 a.m. to 10:45 a.m.

"Aging and Nutrition," Vernon Young, M.D., Professor of Nutritional Biochemstry, Massachusetts Institute of Technology, Cambridge, Mass.

"Alcohol and Nutrition," Charles Lieber, M.D., Professor of Medicine, Mount Sinai School of Medicine, New York, N.Y.

"Diabetes and Nutrition," Jay Skyler, M.D., Professor of Pediatrics, University of Miami School of Medicine, Miami; and John Malone, M.D., Professor of Pediatrics, University of South Florida College of Medicine, Tampa.

"Vitamin and Mineral Use and Misuse," Victor Herbert, M.D., Professor of Medicine, Mount Sinai School of Medicine, New York, N.Y.

Friday, May 25—1:30 p.m. to 5:00 p.m.

Nutrition Workshops (Roundtable Discussions)

THURSDAY AFTERNOON — MAY 24

SECTION ON INTERNAL MEDICINE

(Co-sponsored by American College of Physicians and Florida Society of Internal Medicine)
Thursday—1:30 p.m. to 5:30 p.m.
Eugene T. Davidson, M.D., Lakeland
Program Chairman

"Advances in Clinical Neuroendocrinology," Seymour Reichlin, M.D., Chairman of the Department of Medicine and Chief of the Division of Endocrinology, Tufts University School of Medicine, Boston, Mass.
"Cardiac Arrhythmias and the Newer Anti-Arrhythmic Drugs," Henry McIntosh, M.D., The Watson Clinic, Lakeland.
"Neurological Problems Most Frequently Missed by the Internist," Robert Schwartzman, M.D., Department of Neurology, University of Miami School of Medicine, Miami.
"Neuroendocrine Pharmacology" (Panel)

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Chapter, American College of Chest Physicians, and Florida Thoracic Society)
Thursday—1:30 p.m. to 5:30 p.m.
Allan L. Goldman, M.D., Tampa
Marcos Barrocas, M.D., Miami
Program Co-Chairmen

Introduction — Allan L. Goldman, M.D., Associate Professor of Medicine and Chief, Pulmonary Disease Service, University of South Florida College of Medicine, Tampa.
"Infective Endocarditis," Louis Weinstein, M.D., Physician and Director of the Clinical Services, Division of Infectious Disease, Peter Bent Brigham Hospital, Boston, Mass.
"Legionnaire's Disease," Joseph H. Bates, M.D., Chief of the Medical Service, Veterans Administration Hospital, Little Rock, Ark.
"The Immunocompromised Host," Jay Sanders, M.D., Professor of Medicine, University of Miami School of Medicine, Miami.
"Tuberculosis Therapy Update," David A. Solomon, M.D., Assistant Professor of Medicine, Pulmonary Disease Section, Department of Internal Medicine, Veterans Administration Hospital, Tampa.

SECTION ON RHEUMATOLOGY

(Co-sponsored by Florida Society of Rheumatology)
Thursday—1:30 p.m. to 4:00 p.m.
Selden Longley, M.D., Gainesville
Program Chairman

"Approach to the Rheumatic Patient," Prof. W. Watson Buchanon, Consultant in Charge, Centre for Rheumatic Diseases, Glasgow, Scotland.
Questions and Answers
"Recreational Rheumatism," Richard S. Panush, M.D., and Selden Longley, M.D., University of Florida College of Medicine, Gainesville.
Questions and Answers
"Juvenile Rheumatoid Arthritis," Bernard Germain, M.D., University of South Florida College of Medicine, Tampa.
"Joint Imagining in Rheumatic Disorders," Roy Altman, M.D., University of Miami School of Medicine, Miami.

FRIDAY MORNING — MAY 25

SECTION ON PSYCHIATRY

(Co-sponsored by Florida Council of District Branches of the American Psychiatric Association)
Friday—8:00 a.m. to 10:45 a.m.
Sanford Jacobson, M.D., Miami
Program Chairman

"Biochemical Factors in Schizophrenia and Orthomolecular Therapy," Sanford Jacobson, M.D., Clinical Associate Professor of Psychiatry, University of Miami School of Medicine, Miami.
Discussion
"Lunar Influences on Behavior," Arnold Lieber, M.D., Clinical Assistant Professor of Psychiatry, University of Miami School of Medicine, Miami.
Discussion
"Developments in Psychopharmacology," Benjamin Brauzer, M.D., Associate Professor of Psychiatry, University of Miami School of Medicine, Miami.
Discussion
"Obesity and Related Disorders" (Panel)
Panelists:
William A. Nixon, M.D., Clinical Associate Professor of Psychiatry, University of Miami School of Medicine, Miami.
Sanford Jacobson, M.D., Miami.
Other Panelists to be Announced.

SECTION ON ORTHOPEDIC SURGERY
(SECTION I)

(Co-sponsored by Florida Orthopedic Society)
Friday—8:00 a.m. to 10:50 a.m.
H. Gerard Siek, Jr., M.D., Clearwater
Program Chairman

Welcome — James F. Richards, Jr., M.D., President, Florida Orthopedic Society, Orlando.
"Muscle Pedicle Bone Graft Technique," G. E. Vaga, M.D., Tampa.
"The Modern Charnley Technique of Trochanteric Re-attachment—350 Cases," Louis P. Brady, M.D., Orlando.
"Hip Hemi-Arthroplasty With the Universal Proximal Femur Prosthesis," Nile R. Lestrange, M.D., Ft. Lauderdale.
"How Nuclear Medicine Can Help the Orthopedic Surgeon," Ronald Levy, M.D., Miami.
"Operative Arthroscopy — Low to No Morbidity," John P. Barrett, Jr., M.D., Clearwater.
"Loss of Active Adduction of the Little Finger Following Trauma," James D. Murphy, M.D., Tampa.

SECTION ON ENDOCRINOLOGY

(Co-sponsored by Florida Endocrine Society)
Friday—8:30 a.m. to 10:30 a.m.
Marvin C. Mengel, M.D., Orlando
Program Chairman

"The Decline of the Glucose Tolerance Test," Eugene Davidson, M.D., Chief of Endocrinology, Watson Clinic, Lakeland.
"Neural Control of the Pituitary Gland—Practical Considerations," Seymour Reichlin, M.D., Ph.D., Endocrinology Division, New England Medical Center Hospital; and Department of Medicine, Tufts University School of Medicine, Boston, Mass.
"Radiation and Cancer of the Thyroid," Samuel Crockett, M.D., Associate Director of Medical Education, Orlando Regional Medical Center, Orlando.
Questions and Answers

FRIDAY AFTERNOON — MAY 25

SECTION ON OTOLARYNGOLOGY
(Co-sponsored by Florida Society of Otolaryngology)
Friday—1:30 p.m. to 5:30 p.m.
James C. Garlington, M.D., Gainesville
Program Chairman

"Brain Stem Evoked Audiometric Potentials," Charles Berlin, M.D., Professor of Otolaryngology, Louisiana State University School of Medicine, New Orleans, La.

SECTION ON CARDIOVASCULAR AND THORACIC SURGERY
(Co-sponsored by Florida Society of Thoracic and Cardiovascular Surgeons)
Friday—1:30 p.m. to 4:00 p.m.
Richard G. Connar, M.D., Tampa
Program Chairman

Discussion topics will be "Coronary Artery Surgery" and "Current Concepts in the Management of Chest Trauma."
Speakers:
Watts R. Webb, M.D., Chairman, Department of Surgery, Tulane University School of Medicine, New Orleans, La.
Dennis F. Pupello, M.D., Director of Cardiac Surgery, Tampa General Hospital, Tampa.

SECTION ON ORTHOPEDIC SURGERY
(SECTION II)
(Co-sponsored by Florida Orthopedic Society)
Friday—1:30 p.m. to 5:20 p.m.
H. Gerard Siek, Jr., M.D., Clearwater
Program Chairman

"Malignant Hyperthermia," David A. D. Rudoff, M.D., Melbourne.
"Physicial Examinations in the High School Athlete," Arthur J. Pearl, M.D., Miami.
"Correctible Elbow Lesions As Seen in Professional Baseball Pitchers," Peter A. Indelicato, M.D., Gainesville.
"Problems of the Pre-Adolescent Athlete and Determination of Playability," Fred Allman, M.D., Atlanta, Ga.
"Orthopedic Care of Running Injuries," Phillip L. Parr, M.D., Gainesville.
"Contrast Tomography in Evaluating Knee Injuries in Athletes," Charles E. Virgin, M.D., Miami.
Movie: "Effect of Hyperextension on Wearers of Football Helmets," Herb Virgin, M.D., Miami.

SECTION ON RADIOLOGY
(SECTION I)
(Co-sponsored by Florida Radiological Society)
Friday—1:30 p.m. to 4:45 p.m.
Arthur D. Graham, M.D., Tampa
Program Chairman

Welcome — John T. Johnson, M.D., President, Florida Radiological Society, Sanford.
"GI Radiology," Thomas Beneventano, M.D., Professor of Radiology, Montefiore Hospital, Bronx, N.Y.
"Nuclear Radiology," Lawrence R. Muroff, M.D., Clinical Associate Professor of Radiology, University of South Florida College of Medicine, Tampa.
"Percutaneous Cholangiography," William C. Walker, M.D., Clinical Associate, University of South Florida College of Medicine, Tampa.
"GI Radiology," Thomas Beneventano, M.D., Bronx, N.Y.

SECTION ON PEDIATRIC UROLOGY
(Co-sponsored by Florida Urological Society and Florida Pediatric Society)
Friday—1:30 p.m. to 4:45 p.m.
Roy P. Finney, M.D., Tampa
Jose Strauss, M.D., Miami
Program Co-Chairmen

"Hematuria and Proteinuria in Pediatrics," Helen Gorman, M.D., Assistant Professor of Pediatrics and Associate Director Division of Pediatric Nephrology, University of Miami School of Medicine, Miami.
"The Current Approach to Urinary Tract Infection in Infants, Children and Adolescents," George A. Richard, M.D., Professor of Pediatrics and Chief, Pediatric Renal-Urology, University of Florida College of Medicine, Gainesville.
"Urologic Management of Meningomyelocele," Ronald W. Sadlowski, M.D., Assistant Professor of Surgery (Urology), University of South Florida College of Medicine, Tampa.
"The International Reflux Study," Dixon Walker III, M.D., Professor of Surgery (Urology) and Professor of Pediatrics, University of Florida College of Medicine, Gainesville.
Panel Discussion

SECTION ON ENDOCRINOLOGY AND NUCLEAR MEDICINE
(Co-sponsored by Florida Endocrine Society and Florida Association of Nuclear Physicians)
Friday—2:00 p.m. to 4:30 p.m.
Marvin Guter, M.D., Miami
Marvin C. Mengel, M.D., Orlando
Program Co-Chairmen

"Thyroid Function Testing with TRH," Fuad Ashkar, M.D., Clinical Associate Professor of Medicine and Radiology, University of Miami School of Medicine, Miami.
"Non-Invasive Adrenal Assessment," George Jacobi, M.D., Miami.
"Adrenal Scanning—A Valuable New Diagnostic Tool," Faith Block, Instructor in Nuclear Medicine, University of Miami School of Medicine, Miami.
Questions and Answers

SECTION ON PATHOLOGY
(Co-sponsored by Florida Society of Pathologists)
Friday—1:30 p.m. to 5:30 p.m.
Morton J. Robinson, M.D., Miami Beach
Program Chairman

"Modern Solutions to Common Endocrine Problems," Joseph Keffer, M.D., Director of Pathology, St. Francis Hospital, Miami Beach.
"The Rationale for the Progressing Thyroid Profile," Joseph Keffer, M.D., Miami Beach
Alfred Lewis Award Lecture — (Speaker to be Announced)

SECTION ON NEONATAL-PERINATOLOGY
(Co-sponsored by Florida Society of Neonatal-Perinatologists)
Friday—1:30 p.m. to 5:00 p.m.
John S. Curran, M.D., Tampa
Program Chairman
"Nutrition of the Neonate"

"Problems, Prospectives, and Advances in Neonatal Nutrition," Lewis A. Barness, M.D., Professor and Chairman, Department of Pediatrics, University of South Florida College of Medicine, Tampa; and Chairman, Committee on Nutrition, American Academy of Pediatrics.
"Recent Developments in the Application of Breast Feeding to Neonatal Care," Roberto Sosa, M.D., Assistant Professor of Pediatrics/Neonatology, University of South Florida College of Medicine, Tampa; and Director of the Neonatal Service, All Children's Hospital, St. Petersburg.
Questions and Answers
"Clinical Experiences and Routine Total Parenteral Nutrition in Very Low Birth Weight Infants," Keith F. Kanarek, M.D., Director of Newborn Services, Orlando Regional Medical Center, Orlando.
"Hyperglycemia in Neonates," Stephen L. Goldman, M.D., Assistant Professor of Pediatrics/Neonatology, University of Miami School of Medicine, Miami.
"Vitamin E and the Premature Infant: Fact or Fiction," John S. Curran, M.D., Associate Professor of Pediatrics/Neonatology, University of South Florida College of Medicine, Tampa.
Questions and Answers

SECTION ON PREVENTIVE MEDICINE
(Co-sponsored by Florida Society for Preventive Medicine)
Friday—1:30 p.m. to 5:00 p.m.
James T. Howell, M.D., Palm Springs
Program Chairman

"Florida's 'State of Public Health'," E. Charlton Prather, M.D., M.P.H., State Health Officer and Director, Health Program Office, Department of Health and Rehabilitative Services, Tallahassee.
"Patterns of Consumption—Tuberculosis," Clifford H. Cole, M.D., M.P.H., Director, Tuberculosis Control Office, Department of Health and Rehabilitative Services, Jacksonville.
Reactor:
David A. Solomon, M.D., Chairman, Florida Committee on Quality Care for the Tuberculosis Patient, Tampa.
"Socially Transmitted Diseases in Southeast Florida," J. Q. Cleveland, M.D., M.P.H., Associate Chief, Office of Disease Prevention, Dade County Health Department, Miami.
"Review of Epidemiological Problems in the State of Florida," S. Stryker, M.D., Epidemiologist Information Specialist, National Center for Disease Control, Atlanta, Ga.

SATURDAY MORNING — MAY 26

SECTION ON ORTHOPEDIC SURGERY
(SECTION III)
(Co-sponsored by Florida Orthopedic Society)
Saturday—8:00 a.m. to 11:45 a.m.
H. Gerard Siek, Jr., M.D., Clearwater
Program Chairman

"Lysosymes and Ochonosis," Houshang Seradge, M.D., Tampa
"Acromioclavicular Joint Separation," Paul A. Lunseth, M.D., and Houshang Seradge, M.D., Tampa.
"Long Term Follow-up of Treatment of Grade III Acromioclavicular Separation by Resection of the Distal Clavicle and Transfer of Coraco-Acromial Ligament," Edward F. Swan, M.D., Titusville.
"Evaluation of Knee Injuries—A Practical Method," Fred Allman, M.D., Atlanta, Ga.
"Harrington Instrumentation with Laminar Wiring," Harry L. Shufflebarger, M.D., Coral Gables.
"When Should an Open Reduction be Done on a Fracture of an Os Calcis?" Wallace E. Miller, M.D., Miami.
"Scapular Fractures: A Review," James L. Cain, M.D., Vero Beach.
"Treatment of Hip Fractures Using Single Type of Internal Fixation Device," Merlin G. Anderson, M.D., Clearwater.

SECTION ON PEDIATRIC SURGERY
(Co-sponsored by Florida Association of Pediatric Surgeons)
Saturday—8:00 a.m. to 12:00 noon
Burton H. Harris, M.D., Jacksonville
Program Chairman

"Airway Management by Tracheostomy," Bradley M. Rodgers, M.D., and James L. Talbert, M.D., Gainesville.
"Correction of Vaginal Atresia and Persistent Urogenital Sinus," Ashok Roychoudhury, Miami Beach. (by invitation), H. Warner Webb, M.D., Albert H. Wilkinson, Jr., M.D., and Burton H. Harris, M.D., Jacksonville.
"Liver Tumors in Children," Farhat Moazam, M.D. (by invitation), Bradley M. Rodgers, M.D., and James L. Talbert, M.D., Gainesville.
"Mycobacterial Lymphadenitis Revisited," Ashok Roychoudhury, Miami Beach. (by invitation), Albert H. Wilkinson, Jr., M.D., H. Warner Webb, M.D., and Burton H. Harris, M.D., Jacksonville.
"Hydrops of the Gallbladder in Children," Thomas Rumley, M.D. (by invitation), Farhat Moazam, M.D., James L. Talbert, M.D., and Bradley M. Rodgers, M.D., Gainesville.

SECTION ON RADIOLOGY
(SECTION II)
(Co-sponsored by Florida Radiological Society)
Saturday—8:00 a.m. to 11:00 a.m.
Arthur D. Graham, M.D., Tampa
Program Chairman

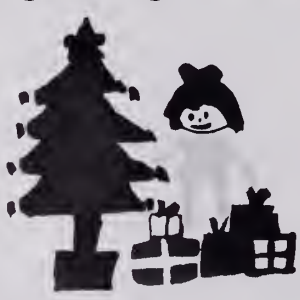
"Quality Control in Radiology" — DuPont Company
"Ultrasonography of the Gall Bladder," Thomas A. Okulski, M.D., Assistant Professor of Radiology, University of South Florida College of Medicine, Tampa.
"GI Radiology," Thomas Beneventano, M.D., Professor of Radiology, Montefiore Hospital, Bronx, N.Y.
"Nuclear Radiology," Lawrence R. Muroff, M.D., Clinical Associate Professor of Radiology, University of South Florida College of Medicine, Tampa.

SECTION ON PEDIATRIC CARDIOLOGY
(Co-sponsored by Florida Association of Pediatric Cardiologists)
Saturday—8:30 a.m. to 10:30 a.m.
Louis E. Cimino, M.D., Tampa
Program Chairman
"Viral Myocarditis," George E. Birch, M.D.
"Bacterial Endocarditis," Stanford T. Shulman, M.D., Gainesville.

SECTION ON ALLERGY
(Co-sponsored by Florida Allergy Society)
Saturday—8:30 a.m. to 12:45 p.m.
Robert H. Cohan, M.D., Pensacola
Program Chairman
Introduction — Robert H. Cohan, M.D., Program Chairman, Florida Allergy Society, Pensacola.
"Differential Diagnosis and Treatment of Eczematous Dermatitis," Stanley I. Cullen, M.D., Associate Professor of Medicine, University of Florida College of Medicine, Gainesville.
"Pathophysiology of Asthma," Allan L. Goldman, M.D., Associate Professor of Medicine and Chief of Pulmonology, University of South Florida College of Medicine, Tampa.
"Allergic Contact Dermatitis," Stanley I. Cullen, M.D., Gainesville.
"Respiratory Insufficiency," Allan L. Goldman, M.D., Tampa.

SECTION ON OPHTHALMOLOGY
(Co-sponsored by Florida Society of Ophthalmology)
Saturday—9:00 a.m. to 10:30 a.m.
G. S. Guggino, M.D., Tampa
Program Chairman
"Ultrasound and Nuclear Medicine in Ophthalmology," Gary Abrams, M.D., and Marvin Guter, M.D.

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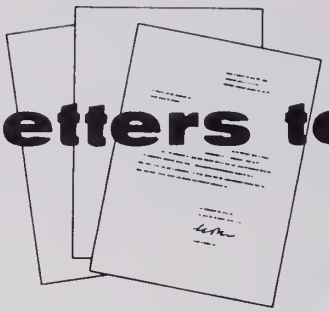
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Letters to the Editors

Addendum

To the Editor: One of the most difficult tasks is to write contemporary history. Many people still alive either have been the actors or have witnessed its different events. Involuntary omissions and mistakes show up immediately causing comic grimaces to the writer.

In this letter I would like to amplify and in some ways correct my paper, *The "General Calixto Garcia" Hospital — Its History,* which appeared in the August 1977 issue of the Journal of the Florida Medical Association.

In the days when venereal diseases, especially syphilis, spread unbridled, serology was one of the busiest sections in the hospital laboratory. Its director, Dr. Alejandro Chediak, tried to simplify the complicated techniques for the diagnosis of syphilis. He developed a serologic examination on a single drop of blood which led to important saving of personnel time. This technique awoke international interest and was adopted by some European armies as a screening test.

When the direction of the hospital changed to the medical school of the Havana University, its Department of Radiology came under the radiology department of the University. Its chairman was Dr. Manuel Viamonte who had been one of the founders of the Cuban League Against Cancer in 1922. He studied under Dr. Francisco Dominguez Roldan, one of the pioneers of Cuban radiology, and had had experience in government as the provisional associate, Dr. Emilio Fiterre, who had won the Albarran prize, enabling him to travel to France and take postgraduate medical teaching, had a brilliant mind but was unfortunately prematurely lost.

The new medical school was finished at the limits of the Calixto Garcia Hospital at 21 and K Streets, the Department of Physiology, like all the basic science departments was moved to the new building named Angel Arturo Aballi honoring the great Cuban pediatrician.

Then the Domingo Cubas building was dedicated to the recently created Department of Parasitology. Its first chairman was Dr. Andres Garcia Rivera and his associates were: Dr. Enrique Llanio and Dr. Pedro Kouri. After the death of Dr. Garcia Rivera, and while Dr. Llanio was temporarily absent, Dr. Kouri was promoted to chairman. As we said in the previous paper, Dr. Kouri and his collaborators began a fight against parasitism and other tropical diseases.

The hospital as we can see was slowly adding new departments and always in full activity as an institution for the medical care of the poor of Cuba and a site of learning for students and young graduates.

The writer wishes to express his gratitude to Dr. Pedro J. Llanio and Dr. Clemente Rodriguez-Remus.

Jose C. Gros, M.D.
Miami

ON COLUMBUS

To: *Edward Pedrero, M.D.*
Assistant Editor, JFMA
Tampa

Dear Dr. Pedrero: I write in response to your article in the August issue of *The Journal of the Florida Medical Association* about Columbus. Your article is extremely well written and fascinates the reader, as though he were placed in the middle of the action.

One can almost sense the expectancy as the ships leave the harbor at the Rio Pinto in 1492 and de Triana's excitement as land is reached on October 12.

You might have said something about Columbus returning in chains on one of his voyages, indicating that great men have their downs as well as their ups.

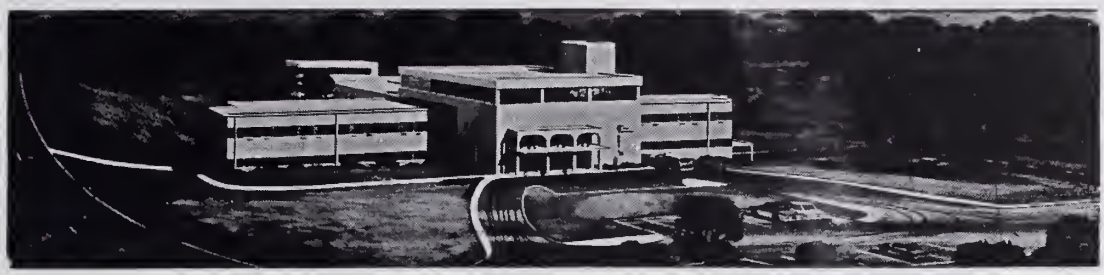
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Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Current Obstetric and Gynecologic Diagnosis and Treatment. Second Edition, edited by Ralph C. Benson, M.D. 976 Pages. Illustrated. Price $18.00. Lange Medical Publications, Los Altos, California, 1978.

The reasonable price of this volume is no indication of this book's value. Although not a text for the specialist in the field, this book will be a valuable addition to the library of medical students, residents and other practitioners who need a readable reference covering any topic in the entire field of obstetrics and gynecology. Forty-two contributors, experts in their areas, have written the various chapters. Pertinent topics covered include: embryology, anatomy, physiology, procedures, psychology, family planning, and legal problems (written by a lawyer), as well as the customary topics in the field of obstetrics and gynecology. The entire field is well covered by the wide diversity of topics. The book is well illustrated with numerous diagrams, photographs, photomicrographs, and also contains many valuable lists and tables.

The format and print allow easy reading for those interested in obtaining information rapidly. The information is concise yet comprehensive enough to be of value to the average reader. This book makes a good starting point for researching information concerning commonly encountered problems as well as for those not so common problems.

There are references at the end of each chapter which have been updated to include the early '78 literature.

In summary, this book is comprehensive in scope rather than depth and extremely practical which makes it worthwhile for everyone except perhaps the specialist. Today, when textbook costs are spiraling upward in price, the publishers of this book are to be commended for the quantity and quality of this reasonably priced text.

Jerrold A. Van Dyke
Gainesville

Mr. Van Dyke is a medical student from the University of Florida College of Medicine and is also an Assistant Editor of The Journal.

Modern Cardiology by John D. Cantwell, M.D. 468 Pages. Price $24.95. Butterworths, Waburn, Massachusetts, 1977.

In a relatively compact volume the author has covered with varying success the broad panoply of current cardiovascular knowledge. Emphasis is on the clinical and practical and reflects, no doubt, the author's own experience. Although full chapters are devoted to echocardiography, stress testing, and His bundle electrocardiography, the use of isotopes and scintography in cardiac disease is discussed only briefly. Other matters as diverse as the bedside evaluation of the jugular pulse and fitness testing of airline pilots are discussed in an straightforward and didactic manner.

Ample references are made in the text and additional reading lists follow each chapter; indeed these are necessary since much technical ground is covered, and the reader is stimulated to seek out the references for further amplification. In this respect the volume serves as a sophisticated handbook wherein much information is presented in large print with frequent section headings. Illustrative material varies in quality and quantity in each chapter.

In summary, the book educates well, is abundantly annotated and fulfills the title's promise in that almost all references have been published after 1977.

Harry W. Eichenbaum, M.D.
St. Petersburg

Dr. Eichenbaum is in the private practice of Internal Medicine in St. Petersburg.

**True friends don't coddle your weaknesses,
They encourage your strengths.**

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Annual Review of Neuroscience with 28 contributing authors. 506 Pages. Illustrated. Price $17.00. Annual Reviews, Inc., Palo Alto, California, 1978.

Pharmacological and Toxicological Perspectives of Commonly Abused Drugs by Darryl Inaba, Ph.D., E. Leong Way, Ph.D., Kenneth Blum, Ph.D. and Sidney H. Schnoll, M.D. 44 Pages. National Drug Abuse Center, Rosslyn, Virginia, 1978.

Currents in Alcoholism, Biological, Biochemical, and Clinical Studies, Edited by Frank A. Seixas, M.D. 601 Pages. Illustrated. Price $31.50. Grune & Stratton, Inc., New York, 1978.

Controlling the Use of Therapeutic Drugs: An International Comparison edited by William M. Wardell. 263 Pages. American Enterprise Institute for Public Policy Research, 1978.

Visionetics, The Holistic Way to Better Eyesight by Lisette Scholl with John Selby. 222 Pages. Illustrated. Price $4.95. Doubleday & Company, Inc., New York, 1978.

Directory of Pathology, Training Programs 1979-80 by the Intersociety Committee on Pathology Information, Inc. 470 Pages. Illustrated. Price $25.00. Geo. W. King, Co., Baltimore, 1978.

General Urology, 9th Edition, by Donald R. Smith, M.D. 541 Pages. Illustrated. Price $14.50. Lange Medical Publications, Los Altos, California, 1978.

Review of Medical Pharmacology, 6th Edition, by Frederick H. Meyers, M.D., Ernest Jawetz, M.D. and Alan Goldfien, M.D. 762 Pages. Illustrated. Price $14.50. Lange Medical Publications, Los Altos, California, 1978.

The Metabolic Management of the Critically Ill by Douglas W. Wilmore, M.D. 262 Pages. Price $22.50. Plenum Publishing Corporation, New York, N.Y., 1978.

Dermatology, An Illustrated Guide, Second Edition by Lionel Fry. 164 Pages. 506 Full color illustrations. Price $19.00. Update Publishing International, Inc., Fort Lee, New Jersey, 1978.

Civilization is just a slow process of learning to be kind.

Charles L. Lucas

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Others Are Saying

A Last Word

Richard S. Hodes, M.D.

A last word from an outgoing president is likely to be replete with reminiscence and reflection. In that respect this parting statement will lay claim to no originality.

The outstanding impression that remains with me looking back over this last year is one of dedication, of responsibility and service by committees and delegates. It has always seemed trite to hear presidents of associations say on leaving office that without my wife Mary or without our dedicated executive director all these wonderful things "we have" (meaning "I have") done couldn't have happened.

The truth of the matter is that the HCMA is a well-established, well-knit and well-run organization. Amelia Hapke is a real pro at association management in every sense of the word, and of course she's the key to the whole operation. But, the Council, Committee members and Delegates have convinced me that organized medicine is alive and well and still ready to meet the health needs of the people.

The repeated forays into the health field by public figures for political advantage have been dealt with by both Public Service and Legislation Committees. Relationships with the political power structure at the local level are remarkably good when one considers the attacks on medical organizations by the state and federal officials. Somebody around here must be doing something right.

Taking the old adage of "physician heal thyself" to its bosom, the Board of Censors has spent many soul-searing hours examining the performance of our colleagues so that we can keep our own house in order. That work prevented damaging press criticism about medicine not being able to police itself.

A little less dramatic but just as trying is the new membership process. Here again the credentials and performance process becomes highly personalized and sensitive. No easy job for the Membership chairman.

A number of interesting programs in preventive medicine and education were developed this year demonstrating enthusiastic activity on the part of committees and individual members. These included involvement in school athletics, school health, hypertension screening, cardiovascular risk factor control and others. Auxiliary activities in school health and political affairs were noteworthy.

Decision making can often be deferred until events force conclusions. Housing for the HCMA offices for a long time has been one of these deferrable decisions. New space needs, lease problems and lack of availability of suitable offices brought the Housing Committee to a decision. There then followed a rapid series of contracts and a remodeling program now almost complete. The time and effort required to allow our association for the first time to occupy its own building cannot be measured in dollars. The expertise of particular members of the Building Committee came into play at each particular phase, each member giving way to the other at critical points. The real estate oriented member with others tied into site and building selection with diligent effort and dedication. After the recommendations were made and the Executive Council decisions reached, another member took on the issues of remodeling contracts and supervision. Cooperating with a third member who dealt with decor and finishing details, each brought his own experience and talents to the forefront in the project. The value in manhours on this job is frightening to contemplate. I only hope future Hillsborough County doctors in retrospect will concur with the decisions.

Some of the proudest moments for the HCMA this year came when awards for Bulletin quality were given at the Florida Medical Association meeting in Hollywood. Our *Bulletin* was declared the leader over all. It was a remarkable accomplishment by our Editor, his staff and the contributors of many excellent articles.

Just before the writing of this page I had the honor of being chosen FMA President-elect. This event while obviously flattering really is a reflection of the kind of a team the HCMA puts together. The choosing of FMA officers like all elections is clearly the end product of election politics. It includes team work, timing, judgment and hard work. The leadership of the Delegation Chairman was as professional and skilled as any

campaign management I've seen in elective politics. His ability to generate enthusiasm and support among our membership and delegates was astonishing. At the convention itself he was tireless. Timing was precise and the Delegates "hung in there" all the way. Each member of the House of Delegates was repeatedly contacted by HCMA representatives who were friends or co-specialists. Position papers were drafted; speeches written and re-written; strategies laid out. In all, the process was a compressed version of any successful political campaign. It was a great deal more skilled than most.

Words cannot express the gratitude I feel for HCMA members and staff for a thrilling year. The teamwork and support culminating in the effort at the FMA meeting will make this year an outstanding one in my memory. No names were mentioned in this column because of the many that deserve to be singled out, none should be slighted by being among others. Again my thanks to all of you.

Reprinted from "The President's Page," of The Bulletin of the Hillsborough County Medical Association, June 1978.

Get Involved

William F. Mallette, M.D.

When Mr. Carter made his recent comment about organized medicine, I was at the FMA annual meeting and was struck by the total inaccuracy of his comments. I had read and heard reports from the 250 committees and subcommittees of the FMA covering every aspect of health care in Florida. There was no comment about physician's fees, how to make money, increased productivity, nor any self-aggrandizing of our profession as would be expected from any industrial, professional, labor or political group.

I did hear one physician after another offer testimony on problems which adversely affect the health of our own people. I heard of multiple bad laws that were being enacted by our state legislature. Inadequate medical care in our prisons, retardation centers and psychiatric hospitals was discussed. The arbitrary and unnecessary regulations of bureaucrats were enumerated. The take-over of Blue Shield by HEW was exposed.

I also heard numerous positive reports of work accomplished in the areas of continuing medical education, specialty medicine, school health, public health, rural health, emergency medical services, Board of Medical Examiners, and many other areas.

The fact that makes Mr. Carter's remarks chilling is that he has unleashed the power of the Federal bureaucracy on those who oppose him. During the past few months FMA has been subject to government interrogation of its activities: IRS — special audit of Florida Medical Foundation; Post Office — revocation of mailing permit; Federal Election Commission — investigating FLAMPAC; Federal Trade Commission — restraint of trade; Justice Department — antitrust.

Mr. Edward Kennedy has also launched a new attack. It is obvious that neither the Federal Treasury nor the Social Security system can sustain his oft touted national health care through funding. He now proposes to organize us through regulation. Advocating his law to control pharmaceuticals he recently said "drugs may be used for any purpose, in any dosage, or in any combination that the individual practitioner wishes. The current system allows individual doctors to substitute their judgment for the Food and Drug Administration."

I have concluded that the ugliness and viciousness of the attack on my profession is likely to increase sharply in the next year. I plan to redouble my efforts in "organized medicine" regardless of the epithet which may be used against me. I ask you who have told me during the year that "medical politics" turns you off to reconsider. If organized medicine doesn't speak for you, maybe it is because you haven't been speaking to organized medicine. The voice that you don't hear may be yours. To those of you who do not wish to become actively involved in the medical organization, I ask you to do the following:

1. Send in your financial support to AMPAC, FLAMPAC and PINPAC.
2. Get involved in the primary campaigns of those seeking office this year.
3. Be aggressive by word and pen to those elected officials who affect you.
4. Continue to practice the excellent medicine which brings honor to you and our profession.

Reprinted from the "President's Message" in the Picomeso Mail Bag of the Pinellas County Medical Society, June 1978.

Disabled Doctors Program
Medical Association of Georgia

G. Douglas Talbott, M.D.

The Medical Association of Georgia became the first state medical society to recognize, implement and finance a Disabled Doctors Program which encompassed all phases of the disease. This included treatment and re-entry of the impaired physician into his or her medical community. Appreciating that ten percent of the physicians sometime in their professional lives become disabled from either alcohol, other drugs, or psychiatric disorders, the Medical Association of Georgia assigned this Program a paramount fiscal priority. Implemented in September of 1975 this Program has contacted and involved over one hundred physicians, returning forty-nine to active, happy, effective and sober practice.

Identification and motivation of the disabled doctor rests in the hands of physicians constituting the Physicians Consultant Committee. Situated throughout the State of Georgia, these twenty-seven physicians are professionally qualified to deal with other impaired physicians because of training in the addiction field, specialization in alcohol and drugs, or recovery from the disease. The Committee may become aware of an impaired physician from peers, nurses, hospital administrators, or more commonly, from spouses. MAG has employed an auxiliary member who is constantly circulating throughout Georgia's twenty-seven medical auxiliaries to alert spouses to the benefit of the Program, its advocacy rather than punitive role, and the rewards of early intervention. Therefore, one-half of all referrals coming into the Program are by virtue of early intervention of the spouses.

Once identification has been formalized and verified, confrontation occurs. The Physicians Consultant Committee then provides two confronters one of whom must have recovered from the disease suffered by the impaired physician. Operating in an advocacy role these two confronter physicians point out the protector role they can afford with the medical society, the licensing board, the hospital, and the hospital staff. In addition, the dangers of trying to continue practice with the threat of legal sanctions by virtue of malpractice are pointed out to the impaired physician. Such advocacy role has met with overwhelming acceptance by the impaired physician. Only two out of one hundred disabled doctors, after repeated unsuccessful attempts at involvement and motivation have had to go to the disciplinary board.

Once agreed to treatment by signing a written contract, the disabled doctor spends four months in treatment, two months both as an inpatient and an outpatient, and an additional two as a practicing physician, under supervision, treating patients suffering from the same disease from which they suffer. Since many of the treatment settings are in marginal financial areas, the impaired physician invariably seems to adopt the philosophy and recognize the reality of "there but for the grace of God go I."

Following the four months treatment phase the physician is assisted in re-entry to his or her medical community or practice, with meetings and educational presentations by the Program staff in their local area. Then there starts a twenty-months surveillance and monitoring aftercare program. This consists of weekly Caduceus Club meetings in Atlanta. These weekly meetings are composed of one hour true peer group therapy for both the spouse and the disabled doctor followed by a meeting of all of the spouses and physicians. The format for the large meetings vary as circumstances dictate. As graduates of the Program have gradually grown, aftercare and surveillance if furthered by "doctors looking after doctors," graduates caring for each other. This is done by frequent visits. In addition, the Medical Director, the Medical Auxiliary Program Coordinator, and the Program Director are constantly circulating throughout the state visiting the physicians back in their professional environment.

While it is still too early in the Program to draw definite conclusions, initial data analysis continues to demonstrate a very high rate of recovery. Intensive, long term, true professional peer group therapy with a structured twenty months monitoring and surveillance aftercare program schedule appear to be the critical elements in this high rate of recovery.

Although Georgia's experience cannot be exactly transported, each state needs a similar program for the disabled doctor. The impaired physician is an extremely valuable, salvageable commodity to the community. Disabled doctors can be treated and the vast majority will recover. Not only an invaluable commodity they enrich the people in the local community in which they reside.

Reprinted from The Imperial Polk County Medical Association Bulletin, June 1978. Dr. Talbott is Director of the Disabled Doctors Program for the Medical Association of Georgia, Atlanta.

What Price Health?

Robert T. Sheen

Today, as never before in the history of mankind, much of our health and longevity is controlled by the individual himself, and a major non-medical determinant of health is the degree to which one assumes responsibility for one's own well being.

"A great deal of what has been written recently about the 'right to health' is misleading. It suggests that society has a supply of 'health' stored away which it can give to individuals and that it is only the stubbornness of the administration or the ineptness of Congress or the selfishness of physicians and hospitals that prevents this from happening. Such a view ignores the truth that positive health is not something that one human can hand to or require of another. Positive health can be achieved only through intelligent effort on the part of each individual.

"The notion that we can spend our way to better health is a vast oversimplification. At present there is very little that medical care can do for a lung that has been overinflated by smoking, or for a liver that has been scarred by too much alcohol, or for a skull that has been crushed in a motor accident.

"In addition, the right to access to health care has little meaning unless citizens have knowledge of available services and facilities, act upon this knowledge, and folow the prescribed regimen."[1]

Most people prefer good health to illness, and a long life to a short one. While individuals are prepared to sacrifice a certain amount of immediate pleasure in order to stay healthy, they are not prepared to forego all self-indulgence, nor to tolerate all inconvenience in the interest of preventing illness. When sickness strikes, however, the patient expects rapid quality care. All available resources must be marshalled on his or her behalf with little regard for cost.

A recent Canadian paper reports on a study in Canada that from age 5 to age 35 the principal cause of death is motor vehicle accidents, the second most important cause is other accidents, and the third is suicide. The three together accounted for 64 percent of the deaths in that age group for the year studied. By age 35, they reported that coronary artery disease first appeared as a significant factor, and over age 40 becomes the principal cause.[2]

Can community health education be effective by increasing knowledge and changing the attitudes of people to avoid the excesses that adversely affect their health? I believe it can.

In a recent paper, a field experiment conducted in three northern California towns is discussed in detail.[3] In two of the communities, extensive mass media campaigns — and in one of these, face-to-face counseling — were provided over a two-year period for a small subset of high-risk people. The third community served as a control. Scientific samplings with regular measurements of the test groups on knowledge of risk factors, saturated fat intake, number of cigarettes per day, plasma-cholesterol, blood pressure, relative ideal weight, over a period of two years showed a definite difference in estimated total risk between control and treatment samples of 23 to 28 percent. This is a very, very interesting paper indeed. It is a positive indication that we can do something about this problem.

Knowledge alone is not enough. In order to improve for the better, habits must be changed. We know in management training, for example, that the knowledge and the skill an individual brings to his work assignments have comparatively little effect on his habits. In fact, there was a study pursued in the University of Michigan over a large number of cases showing the effect of knowledge, skills and attitudes on habits. It was found, for example, that the knowledge and skills a worker brings to his assignments can affect his habits to about 13 percentile. The big answer is attitude. If we expect to change the habits, we must seek to change the attitudes. Health education, therefore, must concentrate not only on knowledge but on the changing of the attitudes of people toward themselves and toward their health with the inculcation of the primary fact that what they do to themselves will have a far greater effect on their enjoyment of life and on their longevity than any pills, medications, or number of trips to a doctor's office can provide.

The war that needs to be fought for those who are truly concerned is a personal war — not a war against government or corporation but against the excesses of the self. If we are going to modify our own destructive lifestyles, we must first recognize they exist; examine our

attitude toward them, and then act with a will and a determination that the life we save or improve may well be our own.

References

1. "An Opinion Leader's Guide — The Value and Cost of Health Care," Tennessee Hospital Association, 1977.
2. "A New Perspective on the Health of Canadians — A Working Document," Ottawa, April 1974.
3. "The Lancet," June 4, 1977 — "Community Education for Cardiovascular Health" by John W. Fraquhar, et al.

Reprinted from HRS ACCESS, June-July, 1978.

Mr. Sheen is Executive Committee Chairman and a Director of Milton Roy Company. He is also Chairman of the Health Care Committee of the Florida Council of 100. This paper was presented before the "Is Your Lifestyle Self-Destructing?" Seminar sponsored by the Florida Council of 100, Blue Cross and Blue Shield of Florida, September 29, 1977, in Miami.

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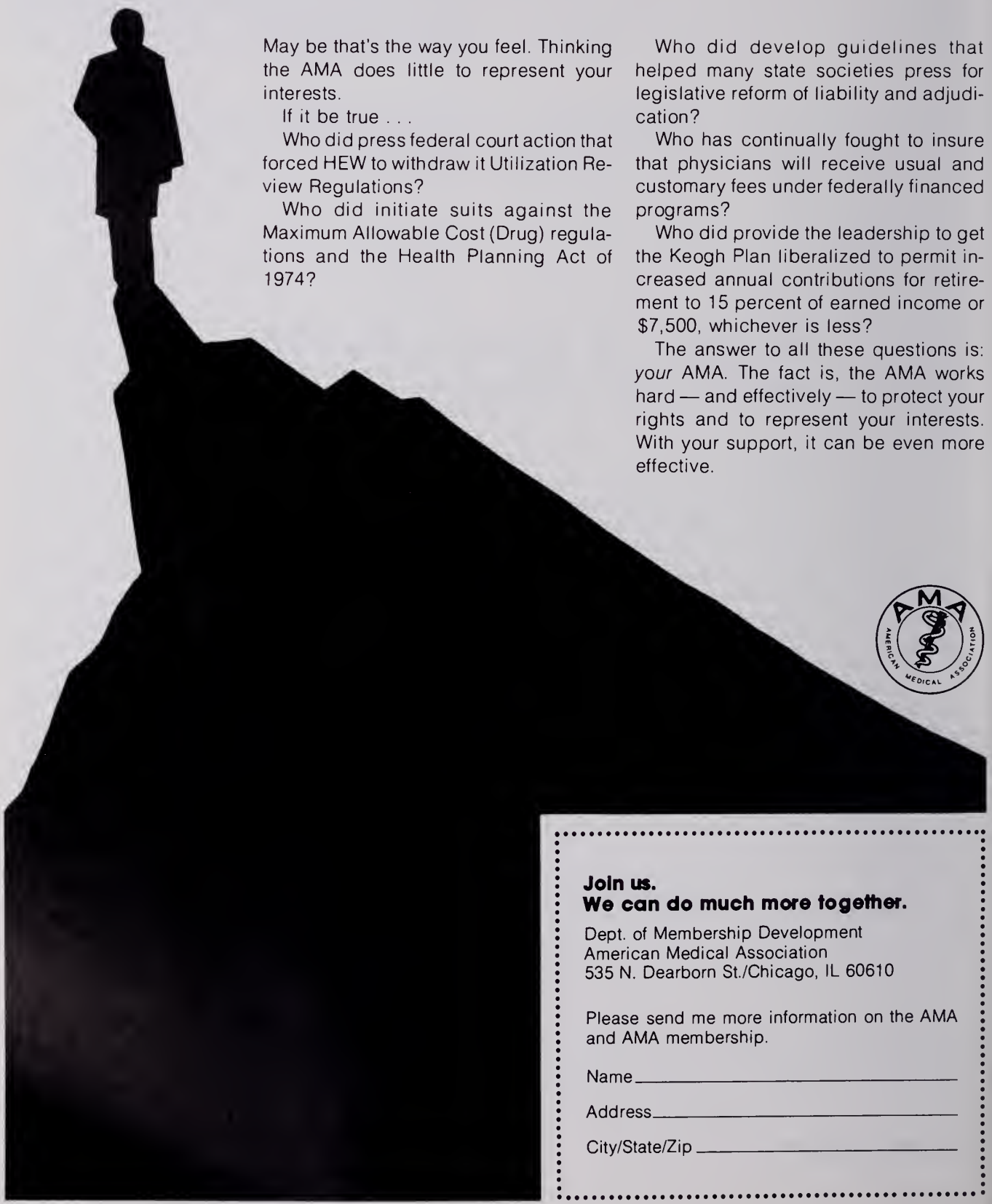
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FMA AUXILIARY

Auxiliary Power

"May 5, 1926, is the date which remains in our memory as the first step in Florida to bring together the wives of our splendid men whose life work is dedicated to aid mankind through the efforts of their chosen profession. We came into their lives as sweethearts, wives and home-makers, while now we have the added pleasure of aiding them in their profession through our new found family group, 'The Woman's Auxiliary'."

Mrs. Wilburn (Anna) Lassiter,
First President of the State Medical Auxiliary

Since its inception, the Florida Medical Association Auxiliary (FMA-A), formerly the Woman's Auxiliary to the FMA, has continually emphasized its original objectives: To assist the Association in its programs for the advancement of medicine and public health needs for the people of Florida; to promote health education and support health-related charitable endeavors; to foster fellowship among the medical community and act as a public relations arm of the medical association. Accordingly, the FMA-A has always actively supported numerous projects beneficial to both community welfare and the medical profession. In the course of such activities and other Auxiliary affairs, members have developed close friendships among themselves throughout the state and a true esprit de corps for their FMA-A. Over the years, the leadership has provided FMA-A members with outstanding educational programs necessary to preserve the effectiveness of the organization. These programs or workshops have kept Auxiliary membership informed of the issues affecting the medical profession, and have offered constructive well-planned projects for FMA-A implementation. By virtue of excellent guidance and incessant hard work, the FMA-A has made invaluable contributions in behalf and support of the FMA; hence, the FMA-A has progressively grown in stature and influence to the extent that "Auxiliary power" should be recognized as one of the medical Association's most potent resources!

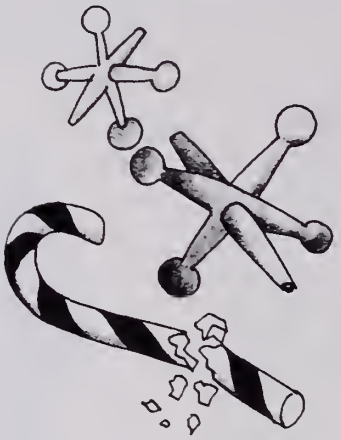
At no time has active membership in the FMA-A been of such paramount importance. The medical profession, faced with increasing public scrutiny and the prospect of impending national health insurance, seriously needs "Auxiliary power." In her report to the FMA's House of Delegates, Mrs. R. B. (Connie) Moore, out-going President of the FMA-A, stressed that all must work together to achieve the goals of the Association. Current Auxiliary projects such as demonstrations of breast self-examination, information concerning the importance of immunization, work to encourage voter registration, and promotion of better health legislation effectively serve to improve the doctors' image while simultaneously raising the standards of health care.

In conclusion, I wish to express my appreciation to Mrs. Thomas B. (Pat) Thames, President of the FMA-A, for the privilege and distinct honor of expressing my views in this Auxiliary page of the Journal. Also, I am grateful to: Wanda McDermon, of the FMA staff, who arranged for me to review the Auxiliary's historical records; Mrs. R. B. (Connie) Moore and Mrs. W. H. (Mary Ann) Mathews, who supplied me with inspiration and ideas; and to my wife whose interest, activities, and overwhelming persuasiveness managed to get me "involved."

Daniel B. Nunn, M.D.
Jacksonville

Postscript from FMA Auxiliary President, Mrs. Thomas B. Thames: Doctor is your spouse a member of the Auxiliary? Alone, we can do something in support of medicine, but if all eligible persons join we can do much more. If there is not an organized auxiliary in your county, contact Mrs. Edson J. Andrews, 832 Washington Street, Tallahassee, Florida 32303 for member-at-large memberships. Our Auxiliary is incomplete without your spouse.

HOLIDAY HAZARDS

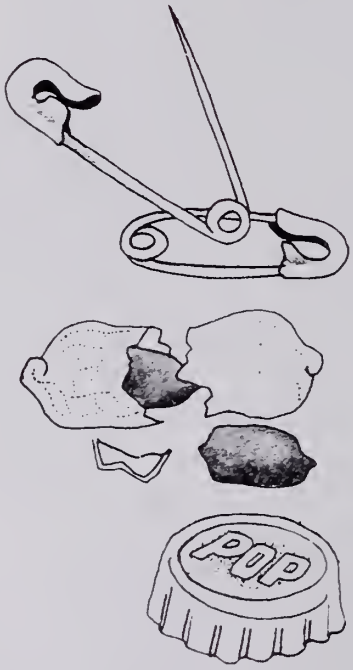


From Halloween to Happy New Year, American homes abound with snack foods, peanuts, candies, trinkets and toys. Attractive to toddlers. And dangerous.

Such small objects can stick in the throat, causing choking—even death. Or be inhaled into the lungs to cause serious trouble.

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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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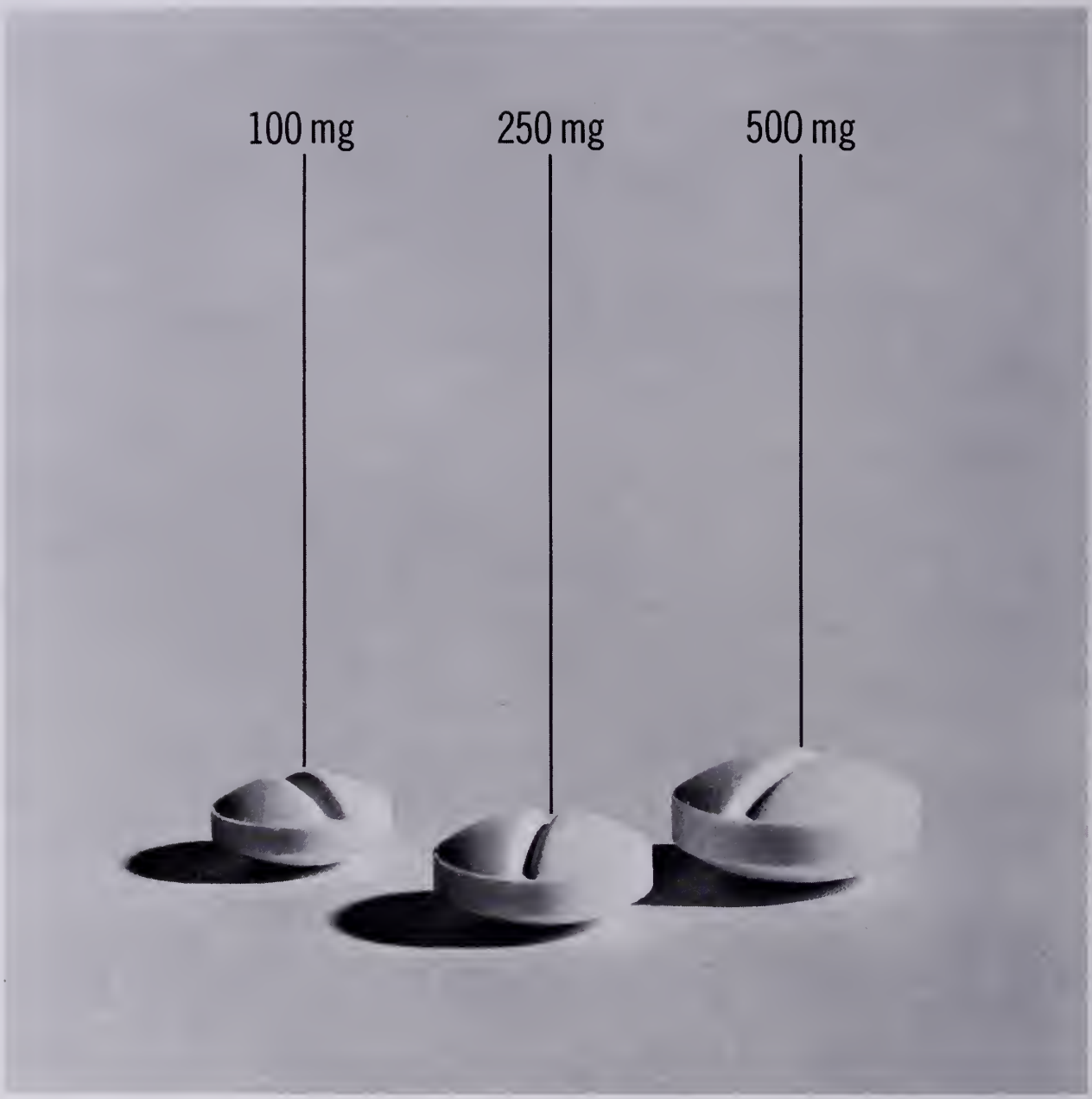
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The FMA Speakers Bureau . . . is servicing requests from county medical societies for Association officers to speak at their meetings.

The Bureau's roster includes FMA President O. William Davenport, M.D.; Past Presidents Vernon B. Astler, M.D., Jack A. MaCris, M.D., Louis C. Murray, M.D., and Joseph C. Von Thron, M.D.; President-Elect Richard S. Hodes, M.D.; Secretary Robert E. Windom, M.D.; Board Members J. Lee Dockery, M.D., Donald G. Nikolaus, M.D., and Thomas B. Thames, M.D., and former Secretary-Treasurer James W. Walker, M.D.

County medical societies may make their requests through the Public Relations Department, FMA Headquarters, Jacksonville.

William O. Russell, M.D., of Fort Lauderdale . . . has been honored by the American Society of Clinical Pathologists and the College of American Pathologists.

Dr. Russell, Director of Pathology at North Ridge Hospital, received the Ward Burdick Award during the organizations' Annual Meeting in St. Louis in September.

The award was established nearly a half-century ago to honor meritorious contributions to the science of pathology for the betterment of patient care.

Dr. Russell until last year was Professor and Chairman of Pathology, University of Texas System Cancer Center in Houston. He is the author or co-author of more than 150 papers.

Love cures people — both the ones who give it and the ones who receive it.

Dr. Carl Menninger

Roger T. Sherman, M.D., of Tampa . . . has been installed as President of the American Association for the Surgery of Trauma.

Dr. Sherman, Professor and Chairman of the Department of Surgery at the University of South Florida College of Medicine, was installed at the Association's Annual Meeting at Lake Tahoe, Nevada.

Henry L. Harrell Sr., M.D., of Ocala . . . has been named to a three-year term on the Board of Governors of the Hospital Corporation of America.

The Board of Governors is a national group of physicians who advises the HCA management on a variety of professional, medical and technical subjects. HCA currently operates 110 hospitals in 25 states and four foreign countries. Sixteen of the hospitals are in Florida.

Dr. Harrell is a former Vice President of the Florida Medical Association and a former President of the Florida Academy of Family Physicians. In 1973, he received the A. H. Robins Company Award for Outstanding Community Service by a Physician.

Allen H. Neims, M.D., Ph.D. . . . has been appointed Chairman of the Department of Pharmacology and Therapeutics at the University of Florida College of Medicine. He comes to Florida after serving for six years on the faculty of McGill University in Montreal.

Dr. Neims succeeds Dr. Thomas Maren, who served as Chairman for 23 years. He resigned recently to accept an appointment as a Graduate Research Professor of Pharmacology.

The new Chairman earned his M.D. degree and Ph.D. in physiological chemistry from Johns Hopkins University. He remained at Hopkins for internship and residency training in pediatrics.

MEETINGS

Approved by the FMA Committee on Continuing Medical Education

DECEMBER

Parenteral and Enteral Nutrition, Dec. 1, Jacksonville Hilton, Jacksonville. For information: Yank D. Coble Jr., M.D., 2700 Riverside Ave., Jacksonville 32205.

7th Annual Refresher Course for Nurse Anesthetists, Dec. 1-3, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

8th Family Practice Review, Dec. 4-8, Candada Beach/LaConcha Convention Center, San Juan, P.R. For information: Bill Rockwood, Gainesville.**

Echocardiography In-Service Workshop, Dec. 4-8, Jackson Memorial Hospital, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Dec. 4-9, Jackson Memorial Hospital, Miami.*

Continuing Physician Seminar-Symposium, Dec. 4-10, Rose Hall Inter-Continental Hotel, Montego Bay, Jamaica. For information: Comer Pharmaceuticals, P.O. Box 5471, Hamden, Conn. 06518.

Advances in Tuberculosis Management, Dec. 6, Broward General Medical Center, Fort Lauderdale. For information: Edward Coopersmith, M.D., 2001 N.E. 48th Court, Fort Lauderdale 33308.

Neuro-Ophthalmology, Dec. 6-9, Key Biscayne Hotel, Miami.*

Glaucoma Symposium, Dec. 7-9, University of South Florida Medical Center, Tampa. For information: W. E. Layden, M.D., P. O. Box 21, MDC, University of South Florida, Tampa 33612.

Orthotics and Prosthetics, Dec. 7-10, Americana Hotel, Miami Beach.*

Hand Surgery, Dec. 8-9, Americana Hotel, Miami Beach.*

Cardiac Symptoms and Arrhythmias — Their Diagnosis and Treatment, Dec. 8-10, Americana of Bal Harbour, Miami. For information: IMEC, 64 Inverness Drive East, Englewood Colorado 80110.

Coronary Disease, Exercise Testing, and Cardiac Rehabilitation, Dec. 8-10, Konover Hotel, Miami. For information: IMEC, 64 Inverness Drive East, Englewood, Colorado 80110.

Vaginal Surgery Seminar, Dec. 10-16, Royal Biscayne Hotel & Racquet Club, Miami.*

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*For information: Contact Division of Continuing Medical Education, D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. Tel. (305) 547-6716.

**For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

Laparoscopy Course, Dec. 11-12, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

High Density Lipoprotein: Results of the Framingham Study, Dec. 14, Manatee Memorial Hospital, Bradenton. For information: Allen R. Sklerov, M.D., 4804 26th St., West, Bradenton 33507.

4th Annual Course in Behavioral Neurology and Neuropsychology, Dec. 14-16, Dutch Inn, Lake Buena Vista. For information: Edward Valenstein, M.D., JHM Health Center, Box J-236, Gainesville 32610.

1979

JANUARY

The 6th Annual Symposium in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Jan. 3-6, Miami.*

2nd Annual Oral Pathology Review, Jan. 8-12, Jackson Memorial Hospital, Miami.*

Art and Science in Therapy of Difficult Problems in Surgery, Jan. 10-13, Americana Hotel, Miami Beach.*

Postgraduate Seminar in Pediatric and Adult Urology, Jan. 10-13, Carillon Hotel, Miami Beach. For information: Victor Politano, M.D., 6614 Miami Lakes Drive, East Miami Lakes 33014 or phone (305) 822-6000.

The Biology & Psychopharmacology of Depression, Jan. 13-14, Innisbrook Golf & Country Club, Tarpon Springs. For information: Howard L. Masco, M.D., 1801 South Boulevard, New Port Richey 33552.

Continuing Education in Pediatrics, Jan. 14-18, Diplomat Resorts, Hollywood Beach. For information: Donald H. Altman, M.D., 6125 Southwest 31st Street, Miami 33155.

First Annual Walt Disney World Pulmonary Wintercourse, Jan. 15-18, Contemporary Hotel, Lake Buena Vista. For information: Asher Marks, M.D., P.O. Box 8127, Jacksonville 32211.

Annual Seminar in Otolaryngology, Jan. 15-18, Doral Country Club and Hotel, Miami Beach.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Jan. 15-20, Jackson Memorial Hospital, Miami.*

Miami Winter Symposia, Jan. 22-28, Intercontinental Hotel, Miami.*

4th Annual Review and Recent Practical Advances in Pathology, Jan. 23-26, Konover Hotel.*

Psycho-Social Aspects of Cleft Palate, Jan. 26-27, Lake Buena Vista. For information: Frances S. Smith, M.D., 1736 University Blvd., S., Jacksonville 32216.

Winter Conference on Principles of Practice Management, Jan. 27-Feb. 3, Lion Square Lodge, Vail, Colorado.*

Vail Conference in Intensive Care, Jan. 27-Feb. 3, The Mark Resort, Vail, Colorado.*

International GI-Family Practice Clinical Conference, Jan. 28-Feb. 2, Dutch Inn, Buena Vista. For information: Orris O. Rollie, M.D., 601 E. Rollins, Orlando 32803.

Laparoscopy Course, Jan. 29-30, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

A Neurological Update 1979, Jan. 29-Feb. 3, Konover Hotel, Miami.*

FEBRUARY

24th Central Florida Medical Meeting, Feb. 1-4, Contemporary Resort Hotel, Lake Buena Vista, Florida. For information: Sam F. Elder, M.D., 601 Rollins Avenue, Orlando 32803.

Morton F. Plant Heart Center, 3rd Annual Cardiovascular Symposium-Valvular Heart Disease in Adults, Feb. 2-3, Caribbean Gulf Hotel, Clearwater Beach. For information: Donald R. Eubanks, M.D., 323 Jeffords St., Clearwater 33517.

Second Symposium on Neurological Surgery of the Ear, Feb. 3-8, Sarasota. For information: Ms. Susan G. Brown, 1845 Hillview Street, Sarasota 33579.

Fifth Annual Vail Conference in Anesthesiology, Feb. 3-10, The Mark Resort, Vail, Colorado.*

Obstetrical and Gynecological Ultrasound In-Service Workshop, Feb. 5-9, Jackson Memorial Hospital, Miami.*

Florida Midwinter Seminar in Ophthalmology and Otolaryngology, Feb. 5-10, Americana Hotel, Miami Beach.*

Imageology 1979, Feb. 16-23, Konover Hotel, Miami Beach. For information: Mrs. Lucy E. Kelley, c/o Medical Seminars, P.O. Box 343762, Coral Gables 33134.

6th Annual Pediatric Dermatology Seminar, Feb. 17-25, M/V Buccaneer, Galapagos Islands. For information: Guinter Kahn, M.D., 16800 Northwest 2nd Avenue, Suite 401, North Miami Beach, Florida 33169.

Pediatric Dermatology Seminar, Feb. 17-26, M/S Buccaneer, Galapagos Islands, South America. For information: Guinter Kahn, M.D., 16800 Northwest 2nd Ave., Suite 401, North Miami Beach 33169.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Feb. 19-24, Jackson Memorial Hospital, Miami.*

Management of the Tiny Baby — 1979, Feb. 22-23, Dutch Inn, Lake Buena Vista. For information: Keith S. Kanarek, M.D., 1416 South Orange Avenue, Orlando, Florida 32806.

OB-GYN Cruise Seminar, Feb. 24-Mar. 6. (Cruise line to be announced).*

12th Pan American Congress of Ophthalmology, Feb. 25-Mar. 2, Fontainebleau Hotel, Miami Beach.*

Laparoscopy Course, Feb. 26-27, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Basic Neurology for Psychiatrists, Family Practitioners and General Practitioners, Feb. 26-Mar. 2, Konover Hotel, Miami.*

Teaching Conference in Clinical Cardiology, Feb. 28-Mar. 3, Americana Hotel, Miami Beach.*

Eleventh Teaching Conference in Clinical Cardiology, Feb. 28-Mar. 3, Americana Hotel, Bal Harbour.*

MARCH

Gynecologic Endocrinology and Infertility, Mar. 1-3, Orlando Hyatt House, Orlando. For information: Bernard Cantor, M.D., Gainesville.**

Symposium on Management of Uveal Melanomas, Mar. 3, University of South Florida College of Medicine, Tampa.+

Postgraduate Medical Refresher Course, Mar. 5-15, Galt Ocean Mile Hotel, Fort Lauderdale. For information: Donald R. Lannin, M.D., 832 Central Medical Building, St. Paul, Minnesota 55104.

Medical Imaging 1979, Mar. 8-10, Royal Biscayne Hotel, Miami.*

Medical Hypnosis and Short-Term Psychotherapy, Mar. 10-14, Americana Hotel, Miami Beach.*

Current Trends in Radioimmunoassay 1979, Mar. 11-13, Royal Biscayne Hotel, Miami.*

Problems in Rheumatology, Mar. 15-18, Don CeSar Beach Resort Hotel, St. Petersburg Beach.+

American and European Views on Anesthesiology, Mar. 24-31, Zermatt, Switzerland.*

Laparoscopy Course, Mar. 26-27, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

APRIL

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 9-14, Jackson Memorial Hospital, Miami.*

Laparoscopy Course, Apr. 23-24, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Sarasota Medical Awards Conference, Apr. 26-29, Hyatt House, Sarasota. For information: S. P. Bralow, M.D., 1515 South Osprey Ave., Sarasota 33579.

Seventh Annual Surgical Intensive Care Symposium, Apr. 27-30 (location to be announced).*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 30-May 5, Jackson Memorial Hospital, Miami.*

MAY

7th Annual Intensive Care Symposium, May 4-7, Eden Roc Hotel, Miami Beach.*

Ultrasound (General) In-Service Workshop, May 7-11, Jackson Memorial Hospital, Miami.**

Laparoscopy Course, May 28-29, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

U.S. POSTAL SERVICE

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Required by 39 U.S.C. 3685)

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11. I certify that the statements made by me above are correct and complete.

SIGNATURE AND TITLE OF EDITOR, PUBLISHER, BUSINESS MANAGER, OR OWNER
Louise Rader, Managing Editor

12. FOR COMPLETION BY PUBLISHERS MAILING AT THE REGULAR RATES *(Section 132.121, Postal Service Manual)*

39 U. S. C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates."

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Louise Rader ,Managing Editor

PS Form 3526
Mar. 1977

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONERS

GENERAL PRACTITIONER: For well equipped medical clinic immediately adjacent to 120 bed skilled nursing facility; would also act as medical director for nursing home. Salary 100% of intake. Contact: Administrator, Wakulla Manor Nursing Home, P.O. Box 508, Crawfordville, Florida 32327. Phone: (904) 926-7181.

GENERAL PRACTITIONER OR INTERNIST: Excellent opportunity, assume long established practice with a multispecialty group. Present associate leaving the area. Florida license required. Please submit curriculum vitae to John F. Kerwick, Hollywood Clinics, P.A., Box 2308, Hollywood, Florida 33022. Phone: (305) 923-4646.

FAMILY PRACTITIONER, board certified, to join 20 man multispecialty group. Please submit curriculum vitae to F. Linn Wagner, M.D. Chief of Staff, Suncoast Medical Clinic, 700-6th Street South, St. Petersburg 33701.

FAMILY PRACTITIONER. Growing community in northeast Florida offers immediate opportunity to establish private practice. Excellent schools, beautiful beaches, year-round outdoor recreation. Contact: Claude Weeks, Executive Director, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

FAMILY PRACTITIONER - INTERNIST: Excellent opportunity for U.S. trained M.D. in established practice. Quality facilities, routine, conditions and freedom. Must send resume and photo to: Harry Rein, M.D., 727 Vassar Ave., Orlando, Florida 32804.

FAMILY PRACTITIONER OR INTERNIST WANTED to share facilities with three practitioners in solo practice. Major equipment provided. Rent $250 per month. Competent laboratory and x-ray departments with income based on use. Bookkeeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

FAMILY PRACTITIONER: Two-man family practice looking for third man. Location South Florida, Pompano Beach area. Write: P.O. Box 757, Pompano Beach, Florida 33060.

FLORIDA KEYS: Family Practitioner for delightful waterfront resort community. Modern, busy, totally equipped, four man, indepth, teaching-oriented family practice. Encourage creativity and expression in growing team. Friendly environment, live the good life, financial security, opportunity for partnership available. 70-bed JCAH hospital adjacent. Need bright, warm, FAMILY PRACTITIONER who cares. Send C.V. to 2855 Overseas Highway, Marathon, Florida 33050 or call Administrator (305) 743-2111 afternoons or evenings.

SPECIALISTS

HEMATOLOGIST-ONCOLOGIST for town in southwest Florida. Write C-885, P.O. Box 2411, Jacksonville, Florida 32203.

BOARD CERTIFIED GENERAL SURGEON — Excellent opportunity for surgeon, preferably with Thoracic or Vascular surgery experience, to practice in expanding North Florida Community. Attractive 128-bed new hospital which provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

EXCELLENT OPPORTUNITY for Board Certified Urologist; needed for fast growing town in coastal southwest Florida. Write C-885, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST — Excellent opportunity for physician to practice internal medicine in expanding North Florida community. No internist currently practicing in community. Attractive 128-bed new hospital which provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

CENTRAL FLORIDA MULTISPECIALTY CLINIC HAS OPENING for second general surgeon. Good financial opportunity; new well equipped office near three hospitals. Write C-893, P.O. Box 2411, Jacksonville, Florida 32203.

ASSOCIATE IN RADIOLOGY NEEDED. Established private practice in metropolitan New Jersey. Knowledge of Spanish helpful. Write C-894, P.O. Box 2411, Jacksonville, Florida 32203.

SEEKING PHYSICIANS TO RELOCATE TO MARIANNA, FLORIDA, trade area of 40,000 people. Professional study and medical staff supports the recruitment of an OB-GYN, Urologist, Orthopedist, Internal Medicine and Emergency Room physicians to supplement the 12 already here. New 90-bed hospital now under construction. Ideal small town living conditions. Financial and business assistance available to qualified physicians. Phone: (904) 526-2200 — Elwin O'Steen.

SURGEON WANTED: Excellent opportunity in growing northwest Florida Community with a modern 34-bed short term General Hospital. No surgeon available in immediate trade area. Community is located ideally between metropolitan areas. Must be receptive to a moderate amount of general practice and possess a Florida license (or qualify to obtain a Florida license promptly). Send curriculum vitae to: Administrator, 401 E. Byrd Ave., Bonifay, Florida 32425.

EMERGENCY PHYSICIAN with postgraduate training or three years experience for prestigious University General Hospital in Tampa, Florida. 600 beds, 45,000 plus visits per year with brand new 17,000 square feet Emergency Department. Guaranteed income for 44 hours per week with two weeks education leave and two weeks vacation. Malpractice paid. Please send curriculum vitae, three letters of recommendation and direct all inquiries to: Philip J. Fagan Jr., M.D., Medical Director, P.O. Box 9639, Marina del Rey, California 90291. Phone: (213) 822-1312.

EMERGENCY PHYSICIANS for central Florida city to work in industrial clinic and minor emergency center. Malpractice paid. Forty hours per week plus paid vacation. Please direct all inquiries to Robert F. Towne, President, Executive Health Services, Inc., 2033 East Edgewood, Suite #5, Lakeland, Florida 33803. Phone: (813) 687-4524.

INTERNAL MEDICINE PRACTICE: Two internists looking for another internist — cardiology training preferable. North Miami Beach area. Drs. Paley & Fieber, 1559 N.E. 164th St., North Miami Beach, Florida 33162.

NEUROLOGIST, badly needed for coastal southwest Florida area. Have CV sent to C-885, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN: Board certified or Board eligible to associate with two busy Pediatricians in central Florida. Write C-903, P.O. Box 2411, Jacksonville, Florida 32203.

EMS CONCEPT now being developed in Orlando, Florida by Medical Emergency Service Associates (MESA), S.C. now hiring only the most qualified physicians to staff emergency departments. High pay, excellent working conditions, flexible scheduling and fringe benefits available to qualified physicians for work in Orlando, Florida emergency departments. Send CV to MESA Florida, P.O. Box 8585, Orlando, Florida 32856.

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LAMINAR FLOW OPERATING ROOMS tested for conformation to Federal Standard 209-B, also yearly recertification test performed. Contact Jake Truslow Company, P.O. Box 1359, Melbourne, Florida 32901. Phone: (305) 723-3382.

PHYSICIANS IN ALL SPECIALTIES NEEDED for new medical center next to TOP OF THE WORLD in Clearwater in condominium area with 7,000 residents, possibly doubling in two years. For information: A. M. Touchette, Realtor, 2380 World Parkway Boulevard, Clearwater 33515. Phone: (813) 733-7752.

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Situations Wanted

GENERAL AND VASCULAR SURGEON, 35, university trained, board certified, Florida licensed. Seeks practice opportunity, solo, partnership or group. Available 3 months notice. Write C-837, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST-NEUROLOGIST, 33, university trained, in two specialties. Would prefer to practice both Internal Medicine and Neurology in multispecialty group or other community situation. Write to Box 221, Glen Oaks, New York 11004.

PATHOLOGIST — Certified CP/AP, Florida licensed, native U.S., excellent C.V. and experience as director. Current postgraduate training and certification through 1980. Write P.O. Box 11158, 227 East Ontario Street, Chicago, Illinois 60611.

SITUATION WANTED: Young cardiologist trained in invasive and noninvasive cardiology (Cath., Angio, ECHO, Treadmill) desires location in Florida. Solo or Associate. Please reply: C-895, P.O. Box 2411, Jacksonville, Florida 32203.

ORTHOPAEDIST — 35, board eligible, married, university trained, experience includes reconstruction and hand with Florida license. Seeks private practice situation. Write: C-897, P.O. Box 2411, Jacksonville, Florida 32203.

SITUATION WANTED: 37 year old, Board Certified, OB-GYN specialist, subspecialty Boards in perinatology, seeks solo or group practice. Write C-899, P.O. Box 2411, Jacksonville, Florida 32203.

BOARD ELIGIBLE NEUROLOGIST, Florida licensed, seeks practice opportunity, partnership or group. Available 2-3 months notice. Write C-902, P.O. Box 2411, Jacksonville, Florida 32203.

GASTROENTEROLOGIST - INTERNIST, 30, ABIM, AOA, university trained. Desires solo or group practice in Florida. Available July 1979. S. Drake, 2823 Littlejohn, San Antonio, Texas 78209.

CARDIOVASCULAR/THORACIC SURGEON, 51. Professor, category I medical school. Extensive experience (cardiopulmonary, esophageal). FRCS (England). FLEX. Florida licensed. Member, Society of Thoracic Surgeons (USA). Recent USA experience (15 months). Available immediately. Seeks academic, group or partnership position. Write Surgeon, 1189 Wynnewood Drive, West Palm Beach, Florida 33409. Phone: (305) 684-0344.

SITUATION WANTED: CARDIOTHORACIC SURGEON, age 32, university trained in General and Vascular Surgery at wellknown Ivy Institution, now completing Board approved Cardiothoracic residency at major east coast university hospital. Seeks position with Cardiothoracic group, or association leading to partnership. Contact: Stewart Fox, M.D., M.S. Hershey Medical Center, Hershey, Pennsylvania 17033.

UROLOGIST, 35, training in midwest major program, excellent in transurethral procedure, seeking group, partnership or solo practice. Available July 1979. Telephone (513) 837-5158.

INTERNIST-ONCOLOGIST, NCI trained, Board eligible, seeking practice association in South Florida in 1979. Please reply to C-884, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL PRACTITIONER, 39, ECFMG, FLEX. Wide practice experience in three foreign countries. Proficiency in French, working knowledge in Spanish. Currently employed in state government agency. Seeks salaried position in South Florida. J. Roger Demosthenes, M.D., P.O. Box 1438, Florence, Arizona 85232. Phone: (602) 723-3805.

FAMILY PRACTITIONER recently recertified American Board Family Practice, 19 years private practice, with part time medical school teaching appointment desires relocation in southeast Florida. Wishes association but will consider solo practice. Florida licensed. Contact V. S. Celestino, M.D., 41 Brandywine Dr., Williamsville, N.Y. 14221. Phone (716) 688-9692 evenings.

ANESTHESIOLOGIST: Florida licensed, university trained, Board eligible, wide experience in all anesthetic modalities. Prefer fee-for-service. Solo or any other reasonable offers considered. Phone (904) 567-7711 evenings.

Practices Available

LAKELAND, FLORIDA: FOR SALE, 6% down. Air-conditioned office for one to three physicians. Main street, 168 x 140 ft.; double parking lots; extra cottage. Dr. L. Polskin, Box 15966, Honolulu, Hawaii 96815.

GENERAL AND VASCULAR SURGERY PRACTICE FOR SALE. Excellent gross. Fully equipped. Very reasonable. Write C-901, P.O. Box 2411, Jacksonville, Florida 32203.

FAMILY PRACTICE AVAILABLE in exclusive neighborhood — 8 years old, St. Petersburg. Phone (813) 577-6928 or (813) 525-0796.

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PRE-SURGERY RELAXATION EXERCISE. Cassette with self-explanatory instructions and subliminal suggestions designed to be played to patients the night before surgery. 31 minutes. Permission given to duplicate for patients. $17. Mindscapes, Inc., 2650 Bahia Vista, Suite 303, Sarasota, Florida 33579.

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OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen, Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone: (904) 398-5500.

FLORIDA — (SOUTHEAST) — DELRAY: Offices for lease in single story medical plaza adjacent to Interstate-95; busy intersection and newly built convalescent center; tremendous opportunity to grow with a rapidly growing middle class community of single-family and condominium dwellings. Contact: Lawrence M. Landis, 900 S. Congress Ave., Delray, Florida 33445. Phone: (305) 278-0062.

FOR LEASE: NEW MEDICAL OFFICE (1,725 sq. ft.) near North Florida Regional Hospital and I-75. Parking space for four employees and six or seven patients. Very near large shopping center on Newberry Road. Will lease for $7 per square foot per year excluding electricity and gas. Contact C. T. Fletcher, M.D., 6830 N. W. 11th Place, Gainesville, Florida (904) 376-5239.

CENTRAL FLORIDA — MAITLAND — CONDO-OFFICE. 1,200 sq. ft. in medical complex. Partially equipped with enough to start practice or as an investment. Four examining rooms. For sale by doctor-owner. Phone: (305) 647-6454.

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LAKE WORTH: General Practitioner has brand new modern office one block from hospital. Prefer to share with a specialist. Write C-900, P.O. Box 2411, Jacksonville, Florida 32203, or phone (305) 686-9565.

PRACTICE IN THE NORTHERN PALM BEACHES! Many specialists needed. New medical building with space for up to 18 physicians located across the street from Palm Beach Gardens Community Hospital now leasing. For information call (305) 844-6585 or 842-1522.

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BAY HARBOR ISLANDS — MIAMI BEACH: Space available in the prestigious Bay Harbor Medical Center in Bay Harbor Islands on Kane Concourse. Convenient off-street parking plus full services. Call Ms. Page (305) 866-1421.

TWO ATTRACTIVE MEDICAL OR DENTAL SUITES (1,250 sq. ft. and 1,035 sq. ft.) in beautiful Coral Reef Professional Building just off U.S. 1. All utilities. Phone (305) 251-3434 from 9 a.m. - 5 p.m. Monday - Friday.

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Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest, concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure, employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

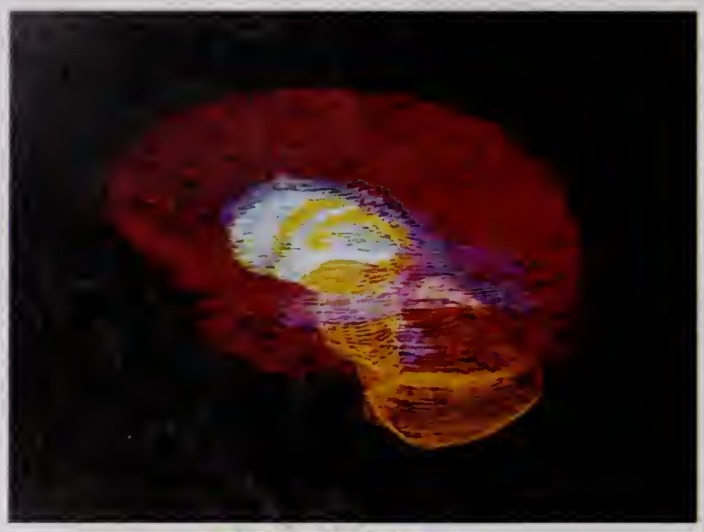
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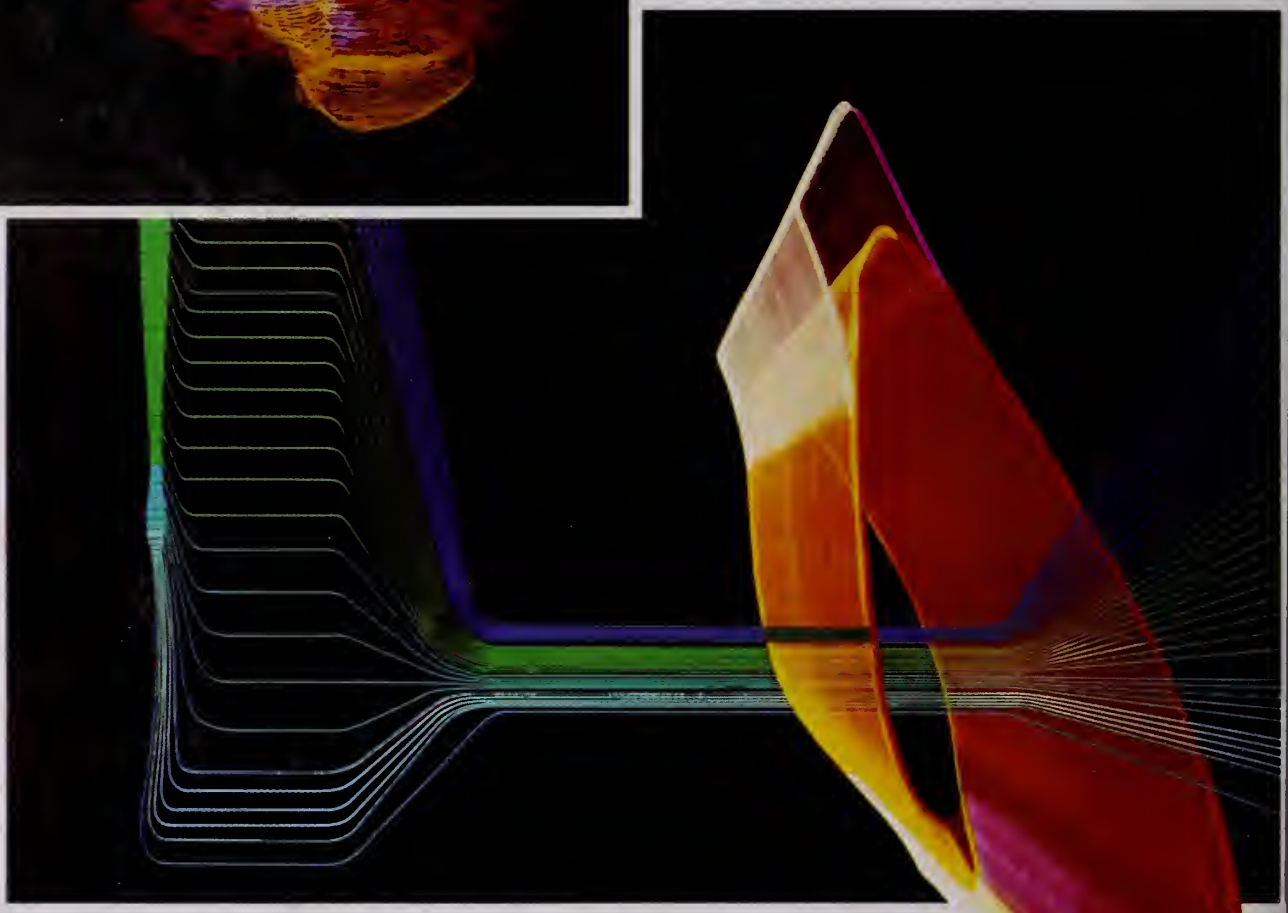


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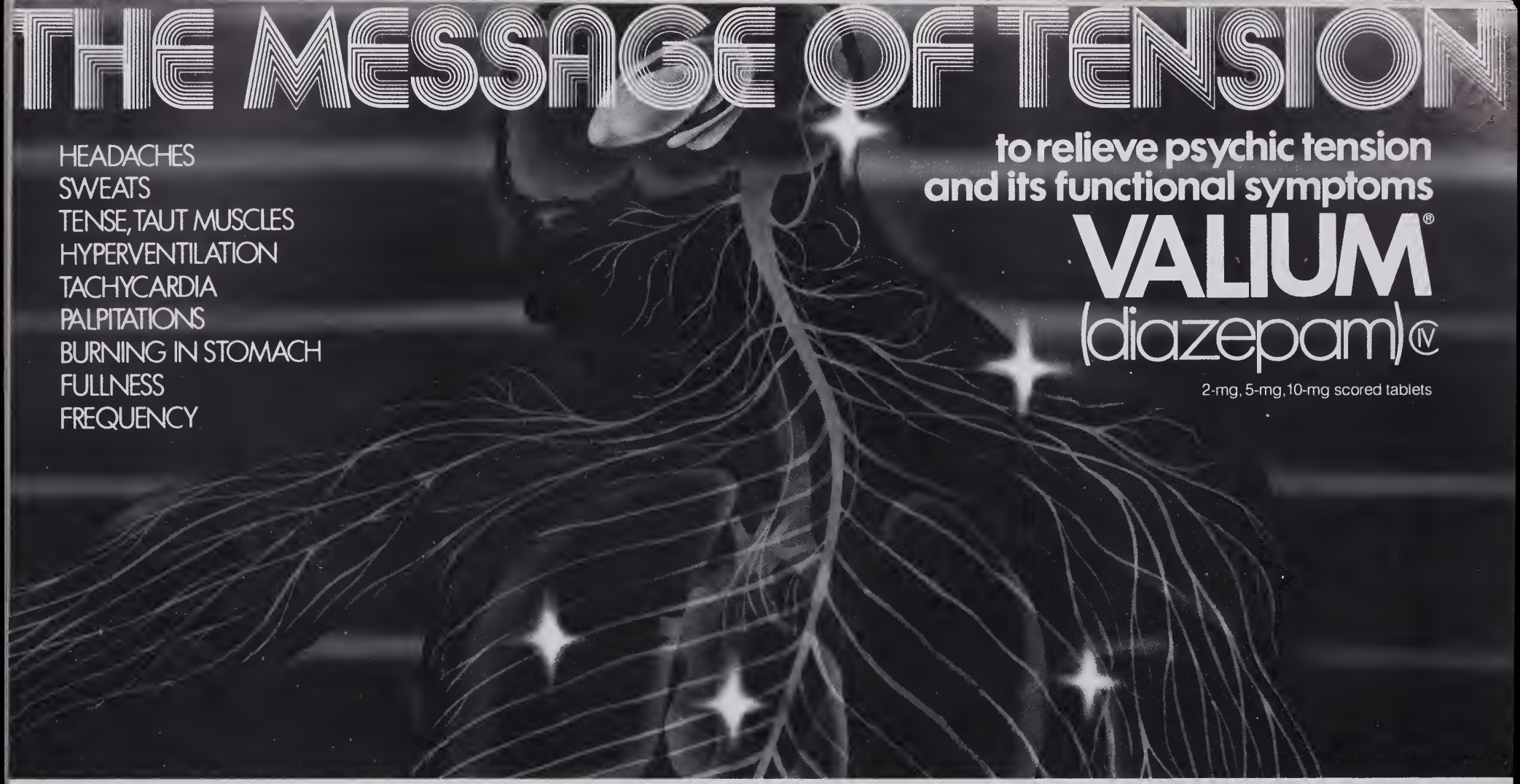
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DECEMBER 1978 • VOL 65 • NO 12

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Before prescribing, please consult complete product information, a summary of which follows:
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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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President's Page

Great News for New Years on Behalf of the Florida Physicians' Insurance Reciprocal

I AM PLEASED TO ADVISE OVER HALF OF OUR MEMBERS OF A RATE REDUCTION AND DIVIDEND FOR YOUR 1979 PLI PREMIUM — 7.35 PERCENT REDUCTION FOR MOST SUBSCRIBERS TO THE RECIPROCAL AND APPROXIMATELY 4 PERCENT DIVIDEND FOR 1978.

Since the inception, the FMA-PLI-Trust and its successor, the Florida Physicians' Insurance Reciprocal, have been successful. The success of the Reciprocal to date is due to many factors. Perhaps the most important has been physician involvement in every facet of the Reciprocal's operation. Forty-four component medical societies have established insurance review committees which have spent untold hours in screening applicants to the Reciprocal and either recommending or not recommending them. In addition, these committees have been involved in an annual review of the Reciprocal members on an on-going basis. Approximately 100 physicians have served as paid medical consultants to the plan, reviewing claims as encountered. Another group of physicians has been involved in giving depositions and testimony before mediation panels and in circuit court trials.

The Board of Directors (Advisory Committee) of the Reciprocal is composed of five practicing physicians, two of whom have served as president of the FMA, one is the current president, one is the president-elect, and the fifth has served on the Board of Governors of the FMA for several years. The Attorney-in-Fact, which is required by law, also serves as the Executive Vice-President of the FMA.

Equally important in the success of the operation has been the tort reforms enacted by the Legislature during the years 1975 through 1978. To date, 11 tort reforms have been enacted, but only two have had a measurable effect to this point in time. The shortened statute of limitations has enabled the plan to close claims after two years and take down reserves, whereas before, a company had to keep these reserves established for an indefinite period of time.

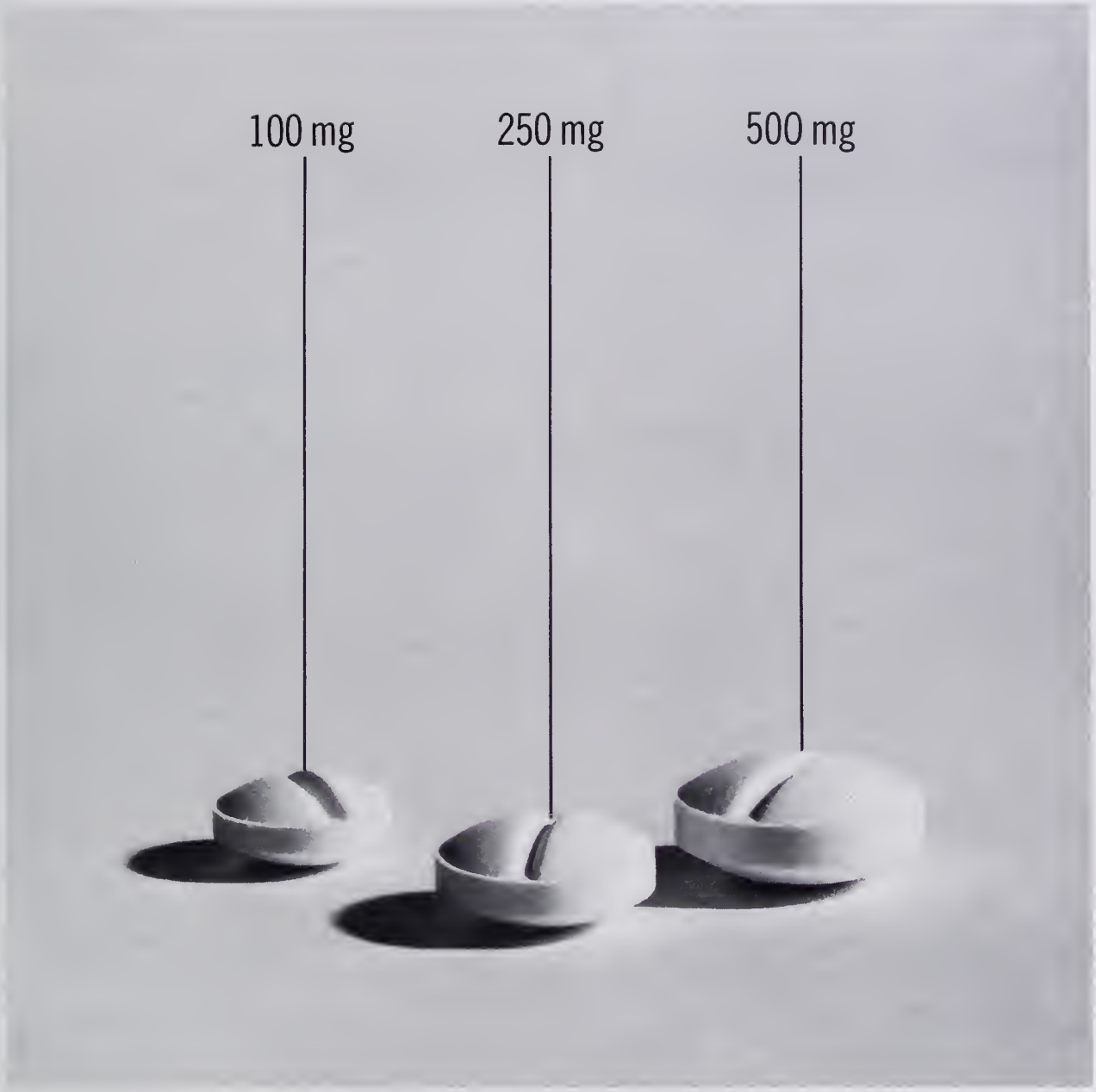
The mediation panels enacted by the 1975 Legislature and later upheld by the Florida Supreme Court have proven to be an expedient and less expensive forum through which to consider the merits of claims and to render an opinion as to the presence or absence of negligence on the part of the physician. The mediation panels have not been popular with plaintiff attorneys, and many plaintiff attorneys have continuously resisted and tried to circumvent these panels. By case law we have attempted to establish that a plaintiff attorney has a responsibility to the physician whom he is suing. Many physicians, attorneys, and circuit court judges have given unstintedly of their time in order to make mediation panels work. Their effectiveness can now be measured by our actuaries and has been reflected in the 1978 premium structure and will be repeated in the 1979 proposed premiums.

After its first year of operation, the Reciprocal did declare a dividend equivalent to 7.35 percent of the 1978 premium. This dividend helped cushion the third-year increase in premiums which was necessary because of the claims-made insurance. An approximate 4 percent dividend has recently been declared which will be applied toward 1979 premiums. Other dividends are under consideration.

As we enter 1979, the fourth-year of operation of the insurance plan, premiums which have been filed and billed reflect that we have turned the corner in spiraling costs of professional liability insurance premium, and the fourth year member **will pay no more** for his insurance .han he did in the third year. This amounts to a **sizable decrease** in the originally anticipated rates as another year of liability is added to the exposure. In addition, our reinsurers have been pleased with the success of the Reciprocal and have agreed to increase the optional limits of PLI coverage to $1.5 million, whereas in 1978 the highest limit available was $1 million. Similarly, because of a strong financial position brought about by expert claims handling, tort reforms, and investment income, the Reciprocal is now able to increase its limit of retention from $100,000 to $200,000 per claim.

The Board of Directors (Advisory Committee) and the Attorney-in-Fact of the Reciprocal and the PIMCO Board of Directors are of the opinion, with cautious optimism, that the acute crisis of medical malpractice insurance has been stabilized.

O. Wm. Davenport M.D.



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DECEMBER 1978 • VOL 65 • NO 12

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DECEMBER COVER — "Florida's Gift From the Sea," a holiday greeting designed by Audrey Schiebler. (Photography by Mr. Terry Walters)

FLORIDA MEDICAL ASSOCIATION, INC.
LEADERSHIP CONFERENCE

Orlando Hyatt House — Orlando, Florida
January 27-28, 1979

The Florida Medical Association will hold a Leadership Conference for County Medical Society officers Saturday and Sunday, January 27-28, 1979, at the Orlando Hyatt House in Orlando, Florida. The conference will begin at 9:00 a.m. on Saturday morning and adjourn by noon on Sunday.

PROGRAM OUTLINE

Saturday — January 27, 1979
Morning Session

8:00 • Registration

9:00 • Presiding — O. William Davenport, M.D.
• Introductory Remarks — O. William Davenport, M.D.
• FMA Priorities, 1978-79 — Robert E. Windom, M.D., Secretary
• Cost of Medical Care — James Richards, M.D., Chairman, Council on Medical Economics
• Legislative Overview — Richard S. Hodes, M.D., President Elect

10:15 • **COFFEE AND COKE BREAK**

10:30 • Public Relations — Vernon B. Astler, M.D., Public Relations Officer
• Scientific Programs — Yank D. Coble, M.D., Chairman, Council on Scientific Activities
• Government Investigations — Jack A. MaCris, M.D., FMA Board of Governors
• Questions and Answers

12:15 • **COMPLIMENTARY BUFFET LUNCHEON**

Afternoon Session

2:00 • Presiding — William W. Thompson, M.D., Vice President
• HSA — Charles F. Tate, M.D., Chairman, Committee on HSA's
• PSRO — Status in Florida — Jack W. MacDonald, M.D., Statewide PSRO Council
• The Impaired Physician — Ray E. Murphy, M.D., Chm., Committee on Membership & Discipline
• AMA — James T. Cook, Jr., M.D., Chairman, Florida Delegation
• Professional Advertising — John E. Thrasher, Esq., FMA Legal Counsel
• Questions and Answers

5:00 • Adjournment

6:30 • **COMPLIMENTARY RECEPTION**

Sunday — January 28, 1979

9:00 • Presiding — James B. Perry, M.D., Chairman, Council on Legislation and Regulations
• FLAMPAC Educational Program — William W. Thompson, M.D., FLAMPAC President
• National Legislation — Louis C. Murray, M.D., Chairman, Committee on National Legislation
• State Legislative Programs — David C. Lane, M.D., Chairman, Committee on State Legislation

10:15 • **COFFEE AND COKE BREAK**
• Presiding — O. William Davenport, M.D., President

10:30 • County Medical Society Programs and Problems:
• Dade County Medical Association — Walter C. Jones, M.D., President
• Escambia County Medical Society — George L. Carr, M.D., President
• Volusia County Medical Society — James G. White, M.D., President
• Questions and Answers

12:00 noon • **ADJOURNMENT**

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Children 6 to 12 years
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Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on:
60 mg tryptophan=1 mg niacin

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Milk. Sometimes we forget all the good things it does.



FROM THE EDITOR'S DESK

VOLUNTARY EFFORT PRAISED

Chairman Barry Bosworth of the Council on Wage and Price Stability has praised the Voluntary Effort to contain hospital costs. "The design of the Voluntary Effort addresses the unique problems of its own field better than any other effort the Council . . . has seen," Bosworth told the VE Steering Committee in October. "We are eager to work with the VE on a cooperative basis and hope to learn from this experience," he added. The Voluntary Effort was organized last year by the AMA, the American Hospital Association and the Federation of American Hospitals. The Voluntary Effort reported in October that the rate of growth of hospital expenditures during the first seven months of 1978 was the lowest since 1974.

CARTER SET BACK

Congress adjourned on October 15 without passing the Administration's top priority hospital cost containment bill. The House refused to take up the measure after the Senate passed a toned-down version. This was seen as a major victory for health care providers which have undertaken a voluntary program, and a major setback for President Carter. Both Carter and HEW Secretary Joseph Califano considered a cost containment law a vital first step toward national health insurance.

CHILD HEALTH

In the push for adjournment, Congress also failed to pass another Administration priority, the Child Health Assessment Program. These other measures got lost in the shuffle: the Health Planning Program extension, with provisions involving physicians' offices and certificate of need; the Clinical Laboratory Improvement Act; the sweeping drug reform measure; and Medicare amendments that included broadened chiropractic coverage.

BILLS PASSED

Congress passed the $56 billion appropriation bill for the Departments of Labor and HEW with compromise language covering federal funding for Medicaid abortions. The Health Services bill containing authorizations for such programs as mental retardation and teenage pregnancy cleared Congress after aid for establishment of primary care centers by hospitals was cut down to a demonstration program. Also approved were aid for biomedical research and the Health Maintenance Organization extension program.

MEDICARE SUIT

The Florida Medical Association has won another round in its court battle to prohibit the Department of HEW from disclosing the names of physicians who received Medicare payments. U.S. District Judge Charles Scott of Jacksonville turned down HEW's request to appeal to a higher court the judge's ancilliary injunction handed down in July. That injunction has prohibited the publication of physicians' names since that time. Judge Scott found unconvincing HEW's argument that the information it wants to release diminishes in value as time goes on.

NHI HEARING

HEW Secretary Joseph Califano joined AMA witnesses in criticizing the National Health Insurance proposal developed by Sen. Edward M. Kennedy and organized labor. AMA witnesses charged in testimony before the Senate Human Resources Subcommittee on Health that the Kennedy plan would result in a "federal takeover" of the health care system. The AMA testimony provoked Kennedy, Chairman of the Subcommittee, into sharp exchanges. In later testimony, Califano, observing that the Kennedy plan would add $30.8 billion to the federal budget by 1983, said the program is too costly.

ANESTHESIOLOGISTS CONSENT

The American Society of Anesthesiologists has agreed it will not take action against members who work under contract to hospitals rather than on a fee-for-service basis. The Federal Trade Commission, which announced the consent order, said the agreement does not imply any admission of violation of law by the ASA. FTC had complained that the ASA advised members they should be compensated only on a fee-for-service basis. Under the order, the FTC said, the ASA must delete from its files "any record of censure" against members for past failure to comply with this policy.

CONFERENCE

Top officials of the AMA met in October with officials and legal counsel of four medical specialty societies. Purpose of the meeting was to attempt to settle differences stemming from a settlement agreement in an anti-trust suit filed by Pennsylvania chiropractors against the AMA and others. Specialty societies involved in the discussions included the American College of Radiology, the American Academy of Orthopaedic Surgeons, the American College of Physicians and the American College of Surgeons.

HEW SHAKEUP

An HEW official who disagreed with Secretary Joseph Califano's belligerent attitude toward health care providers is out of a job. Fired from his job as Administrator of the Health Care Financing Administration was Robert A. Derzon, who held the position for 15 months after a career as a hospital administrator in California. Installed as Derzon's replacement was Leonard D. Schaeffer, 33-year-old Assistant HEW Secretary for management and budget. HCFA is the agency that administers Medicaid and Medicare.

NUTRITION

The nation's medical schools are stepping up their nutrition education programs. The AMA Department of Foods and Nutrition surveyed 124 schools and found that nutrition education has gained recognition as an important component of both medical training and practice. Efforts to provide nutrition courses have increased significantly in the past two years.

CORPORATE VISITATION

Since June, AMA officials have visited with the top management of 28 major corporations in the fields of automobiles, steel, aerospace, oil, food and communications. The discussions have centered on the cost of health care, employers' health care benefits, and the physician's role in cost containment. Without exception, the businesses have welcomed the visits, according to AMA.

OSHA RULE PROTESTED

The federal Occupational Safety and Health Administration wants open access to the files of many private physicians who practice occupational medicine. The proposed rule also would enable OSHA and the National Institute of Occupational Safety and Health to inspect and copy records held by employers. In a statement to OSHA, the AMA said much of the health information in employers' records would be of no value to OSHA and the proposal "reflects the agency's apparent insensitivity" to the issue of confidentiality at a time of great public concern.

HOSPICE

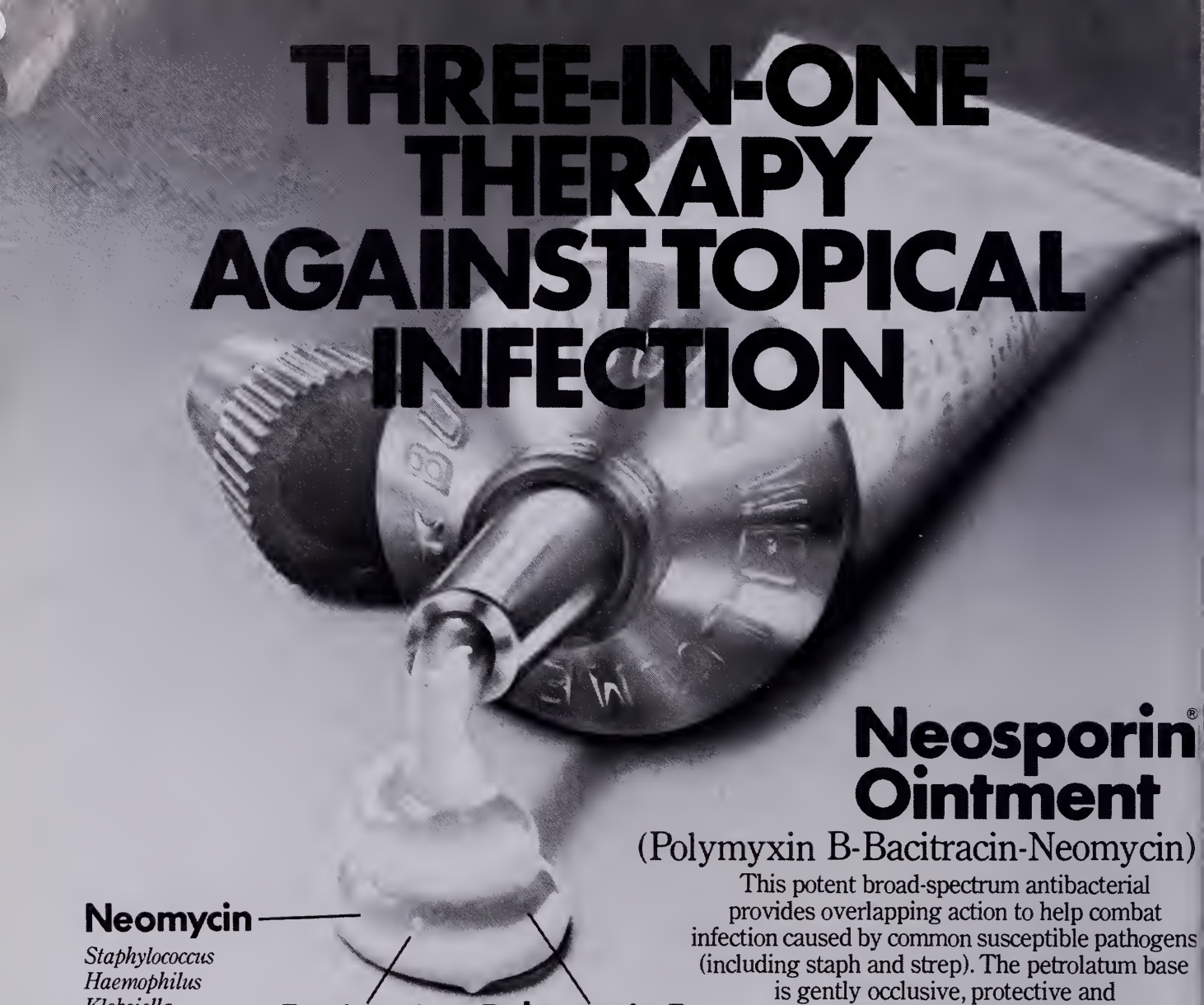
HEW Secretary Joseph Califano says the government will finance special demonstration projects for hospice services. He told the first National Hospice Organization meeting that the program will reimburse for custodial care at home, bereavement counseling, and pain controlling drugs at home. Later, HEW will look into making permanent changes in Medicare and Medicaid to eliminate some of the barriers to reimbursement for care of the terminally ill.

CHECKLIST

AMA's Department of Professional Review has prepared a physician's cost containiment checklist. The list includes more than 30 suggestions for physicians to consider in holding health care costs down. Copies are available free of charge from AMA Order Department, P.O. Box 821, Monroe, Wisc. 53566.

The Editor

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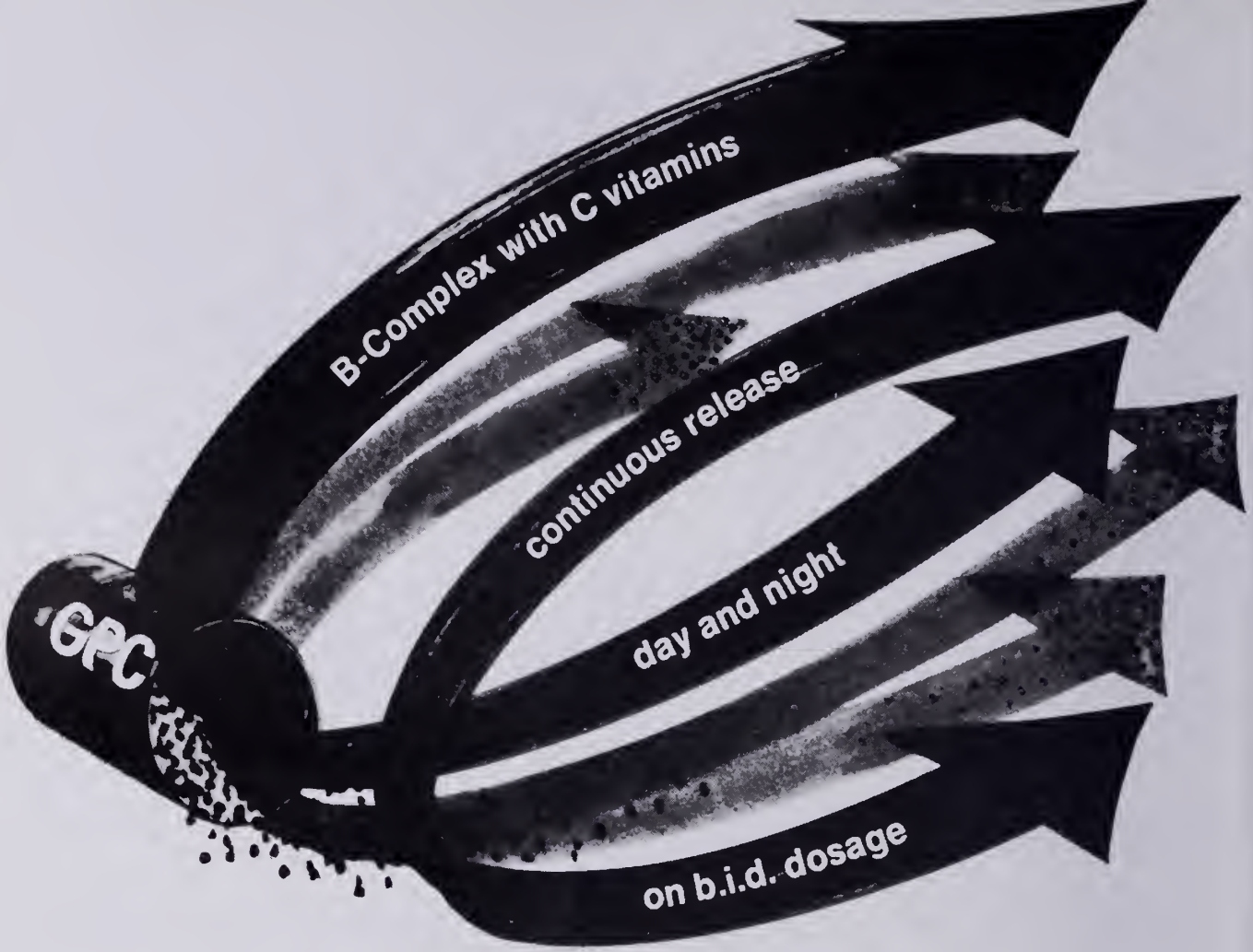
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Dean's Page

Reflections on Flexner

William B. Deal, M.D.

In recent years when record numbers of young men and women in the United States applied for admission to medical school, many were denied admission because of limited enrollment. Many were unqualified. Many of these young scholars applied and were accepted by numerous foreign medical schools.

In the last five years numerous free-standing schools have developed in the Caribbean area and are now known as "off-shore" medical schools. These schools are attracting young Americans in record numbers, and are attempting to provide the students with a medical education with little or no clinical affiliations while charging excessive application, admission, tuition, and transcript fees.

At least one such school in the Caribbean has been banned from using the U.S. Postal Service because of deceptive admission procedures. Others make claims of being accredited by the World Health Organization. The World Health Organization is not an accrediting body but it does publish a directory of medical schools throughout the world. A school in question obtains a listing in the directory by completing the data form and submitting it for publication. This is done in the name of medical education, but for profit. Is medical education turning a full circle and developing a pre-Flexnerian philosophy?

In 1910 a report was submitted to the Carnegie Foundation entitled *Medical Education in the United States and Canada.* This report was a constructively critical masterpiece by Abraham Flexner. It established basic criteria for medical education which are hallmarks of modern medical education. Flexner recognized the necessity for a scientific role in medical education when he stated, " . . . medicine is part and parcel of modern science." Recognizing that premise he prescribed specific criteria for a quality medical education:

(1) The school should be an organic part of a full-fledged university.
(2) The medical courses should be constructed upon an adequate knowledge base of scientific education.
(3) Laboratory instruction should be an integral part of the curriculum.
(4) There must be adequate clinical experience in the major clinical disciplines.
(5) There should be a continuity of service on the part of the teachers of medicine.
(6) The student must be allowed to closely follow the progress of individual patients.
(7) Access of the student to the clinical laboratory is necessary.
(8) Clinical teaching should be done in a "teaching" hospital and clinic.

These criteria are as sound today as they were 68 years ago. Adherence to the criteria are accomplished by U.S. medical schools and adherence is assured by the medical school accrediting agency, the Liaison Committee on Medical Education. Off-shore medical schools do not fulfill these criteria. Furthermore, we should be reminded what Flexner himself said: "It is universally conceded that medical education cannot be conducted on proper lines at a profit."

Flexner would be saddened.

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Jaundice
Clinical Pearls and Perils

Leon Schiff, M.D.

Abstract: The technical advances — particularly radiologic — and laboratory tests, such as determinations of the fractional and total serum bilirubin, serum alkaline phosphatase and serum transaminases in particular — have proved so valuable in the diagnosis of the causes of jaundice as to supersede the clinical examination of the icteric patient. Valuable diagnostic aid is still to be obtained by a careful history and physical examination (with emphasis on selected features) to serve as a guide in the selection of the more helpful laboratory procedures to the exclusion of the superfluous or least helpful. Not only is appropriate therapy thus expedited but the cost and hazards of medical care are reduced concomitantly. Repeated abdominal examinations may often prove rewarding in detecting hepatomegaly, splenomegaly or a distended gallbladder, overlooked because of a hurried examination or poor abdominal relaxation.

Technical advances in diagnosis of the causes of jaundice particularly percutaneous "skinny needle" cholangiography,[1] endoscopic retrograde cholangiopancreatography,[2] and abdominal ultrasonography[3] are proving so valuable as to threaten to supersede clinical examination of the icteric patient. Similarly, so much reliance is placed on concentration of the serum transaminases in the differential diagnosis of jaundice as to divert the physician from a careful history and physical examination. The great advances and their employment when indicated are obvious, but their value is enhanced by a careful clinical examination from which the following symptoms and signs and laboratory tests have been selected for discussion.

From the Department of Medicine and Division of Hepatology, University of Miami School of Medicine, Miami.

History

Abdominal pain. Careful inquiry should be made regarding the presence, location, severity and character of abdominal pain. Epigastric pain radiating to the back, worsened in the recumbent position and lessened on assuming the prone position, lateral decubitus or flexion of the spine, is highly suggestive of pancreatic cancer.[4] The pain frequently requires an opiate for relief but may respond to aspirin (personal observation).

Abdominal pain is not prominent or absent in patients with viral hepatitis who are much more apt to complain of an uncomfortable, dragging or aching sensation in the epigastrium or right upper abdomen. It may be so severe, however, as to suggest gallstone colic. Alan Redeker told me of a similar incident in which a high titre of HBsAg directed attention to an acute Type B hepatitis. A possible mechanism is the presence of a true catarrhal choledochitis (with viscid bile) as the basis of this disorder.

In common duct stone the pain is generally colicky, though more steady and less fluctuating than that of intestinal colic and is apt to be accompanied by nausea and vomiting. In a series of 586 patients operated upon during a 30 year period at the New York Hospital, Glenn found that pain was absent in 10% of the cases.[5] He points out that a calculus may cause gradual occlusion of the common duct in a manner somewhat similar to that taking place in carcinoma of the pancreas, and particularly in elderly and debilitated patients may be mistaken for carcinoma of the pancreas or ampulla of Vater.

The pain of alcoholic hepatitis may be so dramatic and accompanied by such severe right upper abdominal tenderness, fever, leukocytosis and elevated serum alkaline phosphatase as to suggest extrahepatic biliary obstruction and lead to needless laparotomy.

Chills and fever, though usually attributable to cholangitis associated with common duct stone, may occur in drug-induced liver injury and during the preicteric phase of viral hepatitis and leptospirosis. When they follow rather than precede the appearance of icterus, the presence of uncomplicated viral hepatitis is unlikely. A true shaking chill is usually accompanied by chattering of the teeth in contrast with a mere feeling of chilliness.

Marked weight loss and weakness may occur in patients with acute viral or alcoholic hepatitis as the result of anorexia and nausea. These complaints may mislead one into suspecting a malignant hepatic neoplasm.

While a history of alcoholism should suggest alcoholic liver disease, it may prove misleading. This may be particularly true in a young alcoholic whose jaundice may be due to viral rather than alcoholic hepatitis.

Abdominal Examination

Liver size. A presumably large liver, i.e., one extending 3-4 fingerbreadths or more below the right costal margin, would tend to exclude a recently acquired viral hepatitis in favor of cirrhosis, malignant neoplasm, congestive failure, fatty vacuolization, polycystic liver or amyloid disease. The absence of a palpable liver after two to three weeks or more of jaundice would tend to exclude pancreatic cancer as the cause of the icterus because the existing complete and persistent bile duct obstruction should produce enough cholestasis by that time to result in hepatomegaly. On the other hand, absence of a palpable liver does not exclude an hepatic neoplasm, as in hepatoma invading a shrunken, cirrhotic liver.

Liver consistency. In the presence of obvious acute viral hepatitis, a firm liver should suggest preexisting liver disease and would indicate needle biopsy to confirm this suspicion. The liver in acute viral hepatitis is usually of a relatively soft consistency.

Liver contour. A nodular liver surface may escape clinical detection. On the other hand palpation of a grossly nodular liver does not necessarily imply tumor invasion as it may occur in macronodular cirrhosis, polycystic liver or tertiary syphilis of the liver. When found in a patient with cirrhosis who is harboring a malignant neoplasm, laparoscopy with guided needle biopsy of the liver may be needed to detect the tumor.

Perihepatic friction rub is most commonly due to tumor extension through the liver capsule. Like the rub which occurs in fibrinous pericarditis, it may appear intermittently and should therefore be looked for repeatedly.

Bruit over the liver. A harsh bruit over the liver, at times intensified during systole and not affected by posture or increased pressure with the stethoscope, is suggestive of hepatoma but has been described also in alcoholic hepatitis and severe anemia and has been personally observed in pyogenic liver abscess.

Distended gallbladder. A distended nontender gallbladder is the most reliable evidence of extrahepatic biliary obstruction, not necessarily neoplastic in origin, as it may be encountered in about one fourth of cases of common duct stone.[6] When present in a jaundiced patient with laboratory tests characteristic of extrahepatic obstruction, surgery is indicated, preferably preceded by percutaneous "skinny needle" cholangiography without need of a preliminary needle biopsy of the liver.

A distended gallbladder is often overlooked because of a hurried examination or poor abdominal relaxation. Repeating the examination on a subsequent visit may be helpful, as it may be in similarly missed hepatomegaly, splenomegaly, abdominal masses or perihepatic friction rubs. The distended organ may be located in the right lower quadrant and attain the size of a grapefruit and thus be mistaken for some other mass. It may be more visible than palpable and may be seen to descend with inspiration and ascend with expiration. I favor the practice of Watson to commence abdominal palpation in the jaundiced patient in the left lower quadrant, keeping an eye on the right upper quadrant during respiration.[7]

Laboratory Tests

Serum Bilirubin

Ratio of conjugated to total serum bilirubin. Watson has emphasized the value of the ratio of conjugated to total serum bilirubin in subdividing cases of jaundice.[7] A ratio of less than 15% would indicate unconjugated hyperbilirubinemia comprising hemolytic disease, Gilbert's syndrome and the Crigler-Najjar syndrome while a value between 15% and 40%, which he designates as semiconjugated, characterizes liver disease with a hemolytic component or hypersplenism and hemolytic disease with liver injury. Ratios exceeding 40% are to be found in cholestasis due to biliary obstruction or liver disease.

Maximum concentration. A total serum bilirubin value of less than 10 mg% is usually encountered in common duct stone while greater concentrations favor obstruction due to neoplasm. The peak concentration of total serum bilirubin in acute viral hepatitis is usually 15 mg% but may reach higher levels. A total serum bilirubin

concentration of less than 5 mg% is characteristic of uncomplicated primary biliary cirrhosis.

Rate of increase. A daily increase of 1.5-2 mg% in the total serum bilirubin is characteristic of extrahepatic biliary obstruction;[8] more dramatic rises pointing to hepatitis or hemolytic states.

Serum Transaminases

Serum transaminase determinations have been helpful in the differential diagnosis of jaundice with the characteristic increases of more than 300 units in hepatitis — and in early stages of more than 1000 units — in contrast with lesser increases (usually less than 300 units) in obstructive jaundice. However, in exceptional instances unusually high values may occur in extrahepatic obstructive jaundice.[9-11]

Common bile duct ligation in dogs may lead to SGOT values exceeding 1000 units.[9] Narcotic-induced spasm of the sphincter of Oddi can markedly elevate the transaminases with values of 900 and 1180 having been reported.[9] Both of these phenomena are more pronounced if the gallbladder has been removed.[12] The transaminase values in these circumstances are characterized by a rapid rise and fall within 24-48 hours and are accompanied by an LDH activity of 7-10 times normal values in contrast with a usual two or three-fold increase in viral hepatitis. Ginsberg suggests that the biliary obstruction, perhaps by pressure or by the action of bile per se, may increase the permeability of hepatic cell membranes to SGOT.[9]

Serum Alkaline Phosphatase

The serum alkaline phosphatase is slightly elevated in the usual case of viral hepatitis or uncomplicated cirrhosis in contrast with the more striking elevations in extrahepatic obstructive jaundice, in cholestatic forms of drug or viral hepatitis, "space-occupying" lesions of the liver, and in the earliest stages of primary biliary cirrhosis. Striking elevation in a known cirrhotic patient is highly suggestive of coexisting alcoholic hepatitis, biliary tract obstruction or superimposed hepatoma. Lack of increase of the serum alkaline phosphatase should be considered as evidence against the presence of extrahepatic biliary obstruction.[13]

Conclusion

Clinical examination of the jaundiced patient may provide valuable clues to accurate diagnosis and thus guide the physician in his selection of the more helpful laboratory procedures to the exclusion of the unnessary or least helpful. Not only is appropriate therapy thus expedited but the cost and hazards of medical care are reduced concomitantly.

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There is none so deaf as he who does not listen.

Sexual Identity Disorders in Childhood and Adolescence

George A. Rekers, Ph.D. and Gilbert C. Milner III, M.D.

Abstract: Sexual identity disturbance in children and adolescents may first present to the physician. Screening for further evaluation can be done by understanding the symptomatic patterns of gender disturbance and cross-gender identification. Treatment is based on a thorough medical and psychological assessment of the child and family.

From early childhood to late adolescence patients may manifest symptoms of sexual identity disturbance.[1] Parents may develop worry and concern over their children's behaviors that indicate a problem in sex roles (e.g., demanding to dress consistently in the clothing of the opposite sex and indicating dissatisfaction with their own sex). The parents may experience confusion and shame and turn to the family physician or pediatrician for aid and counseling. The physician must then sort out normal adjustment problems in sexual development from potential gender-related emotional disturbances that require specific interventions. Early detection and treatment of gender-related emotional disturbance is critical, as the adult sexual deviations are particularly resistant to change.[2] The physician should be informed of symptoms in the child that constitute screening criteria for a comprehensive psychological evaluation.

Gender Behavior Disturbance

There are two basic clinical syndromes that may be diagnosed by the physician. The **gender behavior disturbance** occurs in male and female children ages three to 17 and requires two or more of the following symptoms to establish the need for a more comprehensive evaluation:[3] in boys, (a) actual or improvised dressing in feminine clothing; (b) actual or fantasized use of female cosmetic articles; (c) "feminine"-appearing mannerisms, behavioral gestures, or gait; (d) deviant sexual behavior or masturbation patterns or history associated with feminine clothing or articles; (e) aversion to or avoidance of peer activities with other boys, or preoccupation with feminine sex-typed activities and games; (f) the use of high feminine-like voice inflection and/or predominantly feminine speech content; and (g) taking a female role in play.

In girls three to 15 years old, research has not yet established overt predictive indicators of gender behavior disturbance. Gender behavior disturbance in girls is usually not detected because of the relatively greater social acceptance of "masculine" attire and preferences in girls, as contrasted with the social concern over boys wearing dresses, for example. Because the temporary phase of taking on the "tomboy" role is part of healthy emotional development in many girls, the **chronicity** of the following patterns is an important variable before considering any of the following behaviors as potentially symptomatic of gender behavior disturbance in girls: (a) rigid insistence on wearing masculine sex-typed clothing (such as pants that zip in the front) coupled with chronic rejection of dresses, skirts, cosmetic articles, and jewelry; (b) "masculine"-appearing mannerisms, behavioral gestures, postures, and gait; (c) deviant sexual behavior or masturbation patterns associated with masculine clothing items; (d) aversion to or avoidance of peer activities with other girls and preoccupation with playing only with boys with the expressed or implied desire to be considered a boy; (e) the use of an artificially-induced low voice inflection and/or predominantly masculine topics in speech content; and (f) the desire to be called by a boy's name or nickname.

Cross-gender Identification

The second clinical syndrome, **cross-gender identification,** is considerably more serious and indicates a strong desire and preoccupation with actually changing sex. Evaluation for this diagnosis is indicated if, in boys, the following two symptoms are manifested, either alone or combined with any of the symptoms listed under gender behavior disturbance: (a) an expressed desire to be a girl or a woman, or taking female roles in play,

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Drs. Rekers and Milner are Co-directors of the Sexual Identity Diagnostic and Treatment Program which is supported by United States Public Health Service grant #MH 29945 from the National Institute of Mental Health, and which includes team members Arlan L. Rosenbloom, M.D., Professor and Chief of Pediatric Endocrinology, and Wiley C. Rasbury, Ph.D., Associate Professor and Director of Child Services, Psychology Clinic.

including fantasies of bearing children and breastfeeding infants; or (b) a request to have his penis removed or other sex-reassignment medical procedures performed. In girls, cross-gender identification is indicated if the following two symptoms occur either alone or in combination with any of the previously listed symptoms: (a) an 18-month or longer history of having an expressed desire to be a boy or a man, or taking predominantly male roles in play, potentially including fantasies of having a penis; or (b) a repeated request for male hormones, breast removal, or other sex-reassignment medical procedures.

Other Sexual Adjustment Disorders

Besides the two diagnostic entities just mentioned, children from infancy through adolescence may indicate the beginnings of a chronic "sexual deviation" if they exhibit public masturbation, sexual assault behaviors, extreme anxiety over the process of puberty, delinquency or truancy involving sexual acting out, and other sexual adjustment difficulties, or a history of sexual abuse. One or more of the above symptoms would indicate the need for a thorough psychological evaluation to determine whether a psychotherapeutic intervention is necessary.[4]

Various medical conditions may also cause difficulty in the child's sexual adjustment and role identification. In some cases, anatomical abnormalities or chronic diseases of the urogenital system may indicate the desirability of a psychological evaluation and a developmental tracing of the patient's emotional and sexual adjustment.[5] In other rare cases, chronic illness not related to the urogenital system, because of its restriction of physical activities and restriction of peer contact in boys, may interfere with their "masculine" image, and gender identity disturbance may secondarily develop.[6]

Diagnostic Evaluation Procedures

Any of these symptoms show the need for a full diagnostic evaluation to see if there is a specific clinical pattern developing that requires psychotherapeutic intervention. This evaluation consists of (a) a thorough medical examination, including history, physical—particularly external genitalia-examination, chromosome analysis, and sex chromatin studies; (b) psychodiagnostic evaluation,[7] including (1) a standardized clinic play measure yielding scores comparable to norms;[8] (2) a behavioral recording of expressive gestures scored with reference to age-related norms for boys and girls;[9] (3) observations of sex-role behavior in the child's home;[10] (4) an intelligence test to screen for deficits which may interfere with normal identification;[7] (5) human figure drawings analyzed for personality disturbance;[7] (6)the Make-A-Picture-Story Test scored for ratio of male and female figures;[7] (7) an evaluation of father-child and mother-child relationships by interview and by a Family Relations Test;[7] and (8) a Sex Knowledge Test to determine areas of sex education needs; and (c) a comprehensive evaluation of the child's emotional functioning by a child psychiatrist or clinical child psychologist. This evaluation would establish a specific diagnosis and indicate the areas in the child's life in which therapeutic interventions could be made.[11,12]

Case Examples

Clinical research demonstrates that only specialized behavioral treatment techniques have been effective in the sexual identity disturbances of childhood and adolescence.[3,13] Several brief clinical case summaries will illustrate the diagnostic and treatment considerations.

Gender Behavior Disturbance

Case #1—Diagnostic Example: Eight-year-old Paul had a four year history of compulsive play with girl dolls, jewelry, cosmetics, hair ribbons, female clothing and improvised dresses (using towels). He regularly avoided all play with boys and exhibited effeminate gait, arm movements, limp-wrist and body mannerisms. Other boys and girls called Paul "girly" and "sissy" and usually excluded him from their play. The psychological evaluation established a gender behavior disturbance with concurrent disruptive anxiety, depression, encopresis and behavioral noncompliance problems. The medical examination resulted in the diagnosis: "46, XY. Normal XY karyotype. Normal prepubertal male."

Case #2—Treatment Example: At age 7 years 11 months, Wendy was referred for treatment by a clinician who found exclusive dress in male clothing and chronic rejection of feminine clothing and jewelry. Wendy had masculine-appearing gestures and gait, projected her voice to a low pitch and assumed the role of a boy or man in play. She occasionally masturbated in public while rubbing her body up against other girls. A self-monitoring form of child behavior therapy in the clinic resulted in major changes in Wendy's play patterns to the level of normal feminine play and role behaviors with toys. Therapy sessions were extended to the home setting to enhance the stability and durability of the behavior change. The mother-daughter relationship was enhanced by counseling sessions with the mother, and more girls' toys were obtained for Wendy at home. After seven months of psychological treatment, reevaluation indicated normal gender behavioral adjustment and normal emotional development.

Cross-gender Identification

Case #3—Diagnostic Example: Fourteen-year-old Mary was referred for evaluation after she asked her pediatrician for a sex-change operation. Mary stated that she had felt like a boy for as long as she could remember and she preferred to be called "Tom." Her clothing, appearance, voice and gestures were exaggeratedly masculine and her activity and interest preferences were masculine. She was sexually and emotionally attracted to romantic relationships with other girls and she rejected both the roles of homosexual and woman. Evaluation procedures found moderate depression, suicidal ideation, profound cross-gender identity, unsatisfied needs for affection, compulsively masculine behavior patterns, and dull-normal intelligence.

Case #4—Treatment Example: Eight-year-old Carl was treated for his severe cross-gender identity by a comprehensive set of treatment procedures including clinic behavior therapy, token economy behavioral management by parent, consultation with school teachers, athletic training, companionship therapy, family counseling, and counseling of the parent. The detailed treatment procedures, published elsewhere,[3] resulted in a normal gender identity, better emotional and social adjustment, and a reversal from depression to reasonable happiness at the one-year and six-year follow-ups. At age 16 years, Carl is now within normal ranges of sexual identity and emotional development.

Sexual Adjustment Disorder

Case #5—Diagnostic and Treatment Example: A preschool dismissed four-year-old Jane for excessive public masturbation in the classroom which distracted other children. Evaluation found Jane to be prone to emotional upset, overly dependent for her age and enuretic in addition to having unusually high frequency rates of masturbation at home and in the clinic, home by parents, and school by teachers. Whenever masturbation occurred, competing nonmasturbatory behaviors were prompted and reinforced by praise and/or by favorite snacks. After four months of therapy, public instances of masturbation no longer occurred and enuresis ceased, allowing reentry to the classroom. One-year and two-year follow-ups indicate durability of the treatment gains.

Conclusion

Early detection of symptoms of childhood and adolescent sexual identity problems make extensive diagnostic studies and treatment intervention possible. This approach holds promise for preventing many of the adulthood sexual maladjustments and gender dysphorias.

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Our greatest glory consists not in never falling, but in rising every time we fall.

Oliver Goldsmith

Thrombosis of Internal Carotid Artery After Gunshot Injury

Madhavan Ravindran, M.D.

Abstract: Traumatic occlusion of the internal carotid artery is rare in adults. A case is reported of a 51-year-old female who sustained a gunshot wound to the right side of her face. Horner's syndrome subsequently developed on the right side and also thrombosis of the internal carotid artery. A brief review is presented of the relevant literature.

Traumatic occlusion of the internal carotid artery in adults is unusual in contrast to its common occurrence from thrombosis complicating atherosclerosis.[1,2] However, internal carotid artery thrombosis has been reported after penetrating neck injuries,[3,4] surgical operations on the neck,[1] intraoral trauma,[5] and even closed injury to the head and neck.

A patient is presented who sustained a gunshot wound over the right side of her face and in whom thrombosis subsequently developed in the right internal carotid artery. The case is reported because of its rarity and interesting features.

Report of Case

A 51-year-old Caucasian female was at the bar with her husband and an argument arose after they finished two cans of beer. The husband became annoyed and shot her in the face with a .22 caliber gun. He summoned the police who brought her to the emergency room within a few minutes. The patient was known to have labile hypertension but she was not taking any medications.

Examination showed the patient to be alert and communicative but bleeding profusely from her face. The bullet had entered the right cheek as shown by a punctate bluish ecchymotic hole situated about the middle of the nasolabial fold. No exit wound was visible. The right side of her face and neck was swollen with extensive ecchymosis and a black eye rapidly developed. She had some difficulty in opening her mouth; the palate was also swollen and ecchymotic.

The vital signs were stable with a blood pressure of 160/80. Neurological examination showed no abnormality of cranial nerves, motor, sensory or reflex functions. The pupils were symmetric, measuring 2.5 mm in diameter. X-ray showed that the bullet had fragmented, lodging in different parts of the face and neck on the right side with the largest piece located in the soft tissue behind the right zygomatic arch (Fig. 1).

Within the next 12 hours, her neck became considerably swollen on the right side with further extension of ecchymosis and induration. There was also facial and periorbital edema; however, facial movements were fairly well preserved. A distinct pupillary asymmetry had developed, the right one smaller at 1.5 mm in diameter and reacting sluggishly to light. Because of edema and resultant closure of the palpebral fissure, presence of ptosis of the right upper lid was difficult to elicit. Optic fundi were benign and retinal venous pulsations were seen asymmetrically. External ocular movements were full; no other neurological abnormality was detected.

Carotid pulsation was absent on the right side but palpation was difficult due to induration and edema. There was no bruit over the right carotid artery but a soft bruit was audible over the left carotid. An arteriogram done by the femoral route showed complete occlusion of the right internal carotid artery close to its origin (Fig. 2.). The right external carotid artery showed adequate filling of the trunk and branches. The vertebrals and left internal carotid were patent with no significant atherosclerotic changes. Also, there was good circulation across the circle of Willis. Computerized tomography and electroencephalography showed no abnormality.

The patient was treated symptomatically with analgesics and antibiotics. As facial and cervical edema subsided, ptosis of the right upper lid became more manifest. Along with the small asymmetric pupil on the right side, ptosis suggested the possibility of Horner's syndrome from pressure or trauma to the carotid. The concensus was against surgery in view of maximal damage to the right internal carotid artery and scattered location of the bullet fragments even though embolization was feared. Recovery was uneventful and she was discharged after the wound had healed satisfactorily. Four weeks later examination showed the



Fig. 1. — X-ray of the base of the skull showing fragmented bullet with the largest piece located in the soft tissue behind the right zygoma. The bony shadow is blurred due to soft tissue swelling.



Fig. 2. — Right carotid arteriogram showing total occlusion of the internal carotid about 2 cm from bifurcation. The external carotid artery and branches and vertebral, basilar and posterior cerebral arteries are well outlined.

patient to be asymptomatic. Faciocervical swelling had cleared up completely as well as the Horner's syndrome.

Discussion

Internal carotid artery thrombosis is an uncommon but recognized complication of injury to the head and neck. It has been stressed that acute internal carotid occlusion is catastrophic in contrast to gradual occlusion of one or both internal carotids because of development of adequate collateral blood flow either at the circle of Willis or between branches of internal and external carotid arteries.

Successful and uncomplicated acute surgical occlusion of the internal carotid artery in the neck had been accomplished as a treatment for inoperable intracranial aneurysms and arteriovenous malformations. However most reported cases of traumatic thrombosis of internal carotid artery had major complications from cerebral infarction. Mastaglia and co-workers[6] reported two patients who died from traumatic occlusion of the intracranial portion of the internal carotid with probable embolization into the anterior and middle cerebral vessels.

Several theories have been advanced to explain the occurrence of cerebral ischemia after acute internal carotid occlusion in spite of adequate and demonstrable collateral circulation. One of them is direct extension of the thrombus into the anterior and middle cerebral arteries. Another possibility is embolization into the main branches from the primary thrombus. This might explain delayed onset of symptoms in most cases. Poverty of collateral blood flow is a readily acceptable cause in some instances. Reflex spasm of the cerebral vessels in response to carotid thrombosis is another postulate.

The thrombosis itself is variously attributed to traumatic intimal tear,[7] contusion of the vessel wall with or without dissection, arterial spasm and compression of the internal carotid from outside or against the lateral mass of the second cervical vertebra.[8]

The clinical picture of acute carotid occlusion includes contralateral hemiplegia with or without ipsilateral amblyopia if the ophthalmic artery is also

involved, aphasia if the lesion affects the domina hemisphere, epileptic seizures and progressive corr However it may remain completely silent also.

The patient reported here escaped intracran extension and resultant complications of internal carotid artery thrombosis. Her only neurological abnormality was a short-lived Horner's syndrome from involvement of the sympathetic plexus around the carotid which, however, offered the clue to internal carotid artery injury. There was no clinical evidence to suspect a pre-existing internal carotid occlusion. She did not show any significant atherosclerotic changes in the vertebrals and left internal carotid artery. Horner's syndrome was not evident at the time of admission; hence the thrombosis and related abnormalities evolved over a 12-hour period after trauma. Hughes and Brownell[9] had also observed manifestations of carotid occlusion in their series within 24 hours after the initial injury.

Most authors recommend some form of interference including prompt surgical exploration of the region after establishing the diagnosis by arteriography but before the brain becomes seriously affected.[7] Conservative measures are the only possible course if the site of the lesion is surgically inaccessible. Parenteral vasodilators, stellate ganglion block and steroids in high doses could be tried but the response is usually unsatisfactory. Anticoagulation may be beneficial, particularly in embolic episodes, but there is always the risk of added cerebral hemorrhage when cerebral infarction has already occurred.

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Subacute Bacterial Endocarditis in Florida

Stanford T. Shulman, M.D.

Abstract: The Florida Task Force on Rheumatic Fever and Rheumatic Heart Disease solicited information regarding the incidence of Subacute Bacterial Endocarditis (SBE) in Florida by mailing questionnaires to hospital medical record librarians, Florida Fellows of the American College of Cardiology, and members of the Florida Association of Pediatric Cardiologists. Eighty-four percent of responding hospitals reported rates of diagnosis of SBE which were between 1:1000 and 1:10,000 admissions. That SBE has become predominantly a disease of older patients is indicated by the mean age of 52.1 years and the relative paucity of cases among the young. While 15% of patients had no apparent underlying heart disease, rheumatic heart disease in adults and congenital heart disease in children were the most common predisposing factors. Eight patients with SBE were thought to have the prolapsing mitral valve syndrome as an antecedent condition. The need for emphasis upon the use of antibiotics to prevent SBE is dramatized by the finding that only 27% of those SBE patients with history of a recent dental or surgical procedure were thought to have received any form of antibiotic to prevent SBE at the time of the procedure. Attention is drawn to the recently revised guidelines of the American Heart Association for the prevention of bacterial endocarditis.

Subacute bacterial endocarditis (SBE) is a well-known complication of rheumatic and nonrheumatic cardiac disease. The Florida Task Force on Rheumatic Fever and Rheumatic Heart Disease has recently gathered information regarding the incidence of SBE in Florida, predisposing factors, and frequency of administration of prophylactic antibiotics to prevent SBE. These data were sought by mailing questionnaires to (a) the medical record librarian of each hospital in Florida, (b) Florida Fellows of the American College of Cardiology, and (c) members of the Florida Association of Pediatric Cardiologists. The purpose of this report is to present the results of this survey.

Results

Medical record librarians of hospitals in Florida were asked to indicate the number of cases coded as SBE or Infective Endocarditis during 1976 and the first half of 1977 as well as the total number of admissions during the same period. Questionnaires were mailed to 261 hospitals and replies received from 125 (48%).

The results of this survey are shown in Table 1. As can be seen, 59 of 125 responding hospitals did not code cases of SBE during the survey period. These tended to be smaller hospitals with an average of 4,757 admissions during the survey period (range = 1,535 to 13,310). The remaining 66 hospitals reported 302 cases of SBE, an average of 4.6 cases per hospital with a range of 1-20 cases per hospital. The mean frequency of SBE in these hospitals was one case per 4615 hospital admissions, with a range of incidences at individual hospitals from 1:358 to 1:14,506 admissions.

Of 329 Florida Fellows of the American College of Cardiology surveyed (exclusive of those who are also members of the Florida Association of Pediatric Cardiology), 86 (26.1%) responded to the questionnaire. This actually represented a somewhat greater percentage response since, in many instances, one individual responded for a group of cardiologists. Thirty-three respondents (38%) reported that they saw no cases of SBE during the survey period, while 53 (62%) reported a total of 134 cases of SBE. The ages of the 134 patients

Table 1. — Cases Coded as SBE in Florida Hospitals in 1976-1977.

	Number Hospitals	Admissions (Mean & Range)	Ratio of Total Admissions to Cases of SBE (Mean & Range)
A. Hospitals with no cases	59	4,757 (1,535-13,310)	
B. Hospitals with cases	66	11,687 (358-27,163)	4,615 (358-14,506)

This report was prepared for the Florida Task Force on Rheumatic Fever and Rheumatic Heart Disease, Robert E. Windom, M.D., Chairman. Other members include Elia M. Ayoub, M.D., John L. Bonomo, D.D.S., Simon D. Doff, M.D., Mittie Moffett, R.N., Alfred Ogden, M.D., Bernard F. O'Hara, M.D., Gerold L. Schiebler, M.D. (ex officio), Stanford T. Shulman, M.D., Dolores Tamer, M.D., and John Whitcomb, M.D.

ranged from 16 to 91 years, with a mean age of 52.1 years. Twenty of the 134 subjects (15%) had no apparent preexisting cardiac disease (Table 2), the majority of these cases occurring as a consequence of intravenous drug abuse. The remaining 114 patients were thought to have preexisting cardiac disease, with presumptive rheumatic valvular disease considered to be present in 55, congenital heart disease (particularly bicuspid aortic valve) in 13, atherosclerotic heart disease in four, prolapsing mitral valve in seven, and pacemakers in two. In 33 cases the nature of the underlying heart disease was unknown or unspecified.

Table 2. — SBE Cases Reported by Fellows of American College of Cardiology.

Pre-existing Heart Disease		
1. None Known	20	(15%)
2. Known heart disease	114	(85%)
a. Rheumatic heart disease	55	
b. Congenital heart disease	13	
c. Prolapsing mitral valve	7	
d. Atherosclerotic heart disease	4	
e. Pacemakers	2	
f. Unspecified or unknown	33	

Forty-one (31%) of the 134 episodes of SBE were reported to be preceded by a recent procedure such as dental work or cardiac surgery (Table 3). In 60% or 80 patients, there was no known antecedent procedure, while in 13 (9%) this information was not known. Of the 41 episodes of SBE preceded by a procedure, only 11 (27%) had received some form of prophylactic antibiotics, while 25 (61%) had not apparently received antibiotics. In five cases (12%), this history was not available.

Table 3.

Procedure preceding SBE episode?		
1. Yes	41	(31%)
2. No	80	(60%)
3. Unknown	13	(9%)
	134	

Was SBE prophylaxis administered prior to procedure?		
1. Yes	11	(27%)
2. No	25	(61%)
3. Unknown	5	(12%)
	41	

Responses were received from 17 of 23 members of the Florida Association of Pediatric Cardiologists, who reported 12 cases of SBE. These patients ranged in age from five to 25 years of age, with a mean age of 12.3 years. The 12 cases of SBE in youngsters included four patients with rheumatic heart disease, seven with congenital heart disease and one child with a prolapsing mitral valve. In only two patients was there history of a recent procedure, ear-piercing in one and recent cardiac surgery in another, while a third patient was noted to have severely carious teeth. Only the patient who had undergone cardiac surgery had received antibiotics to prevent infective endocarditis.

Discussion

The purpose of this survey was to elicit information regarding the incidence of SBE in Florida and to estimate the frequency with which this illness occurred following dental or surgical procedures which were not adequately covered by prophylactic antibiotics. In this survey, individual cases of SBE were not verified but were included if reported by the hospital or physician respondent. While it is possible that some of the reported cases might not have met strict criteria for the diagnosis of SBE, it is also possible that unrecognized or miscoded cases of SBE occurred which were not reported.

Within this limitation, several conclusions appear to be reasonable from the data collected. Although not an everyday disorder, bacterial endocarditis is not a rare disease. Over 300 cases were reported by the responding hospitals during a period of 18 months. The incidence of SBE, when expressed per total number of hospital admissions (exclusive of obstetrical patients), is somewhat variable ranging from 1 per 358 admissions to 1 per 14,506 admissions. However, 60% of responding hospitals reported a rate of SBE between 1:1000 and 1:5000 hospital admissions, while 84% of hospitals reported a rate between 1:1000 and 1:10,000 hospital admissions. Particularly with the large population of elderly people in Florida, SBE is a significant health problem. This is highlighted by the mean age of 52.1 years in the cases reported by Fellows of the American College of Cardiology and by the relatively small number of cases reported by the Pediatric Cardiologists. This finding is in keeping with the documentation by Weinstein and Rubin that the average age of patients with SBE has risen sharply over the past several decades.[1]

The nature of the heart disease predisposing to the cases of SBE reported here appears to be primarily rheumatic in adults and primarily congenital heart

disease in children, a not surprising finding. Durack has shown that in recent years a decreasing proportion of patients with SBE have had rheumatic heart disease, and an increasing number have had degenerative heart disease, cardiac surgery, drug addiction, immune compromise, or intravenous catheters or devices.[2] It is of interest that our survey revealed at least eight patients considered to have the prolapsing mitral valve syndrome who were diagnosed as having SBE, an association which has been well documented.[3]

A finding of importance with respect to SBE and its prevention is apparent from the data regarding the frequency of dental or other procedures preceding the episode of SBE. As shown in Table 3, in only 31% of the 134 cases of SBE for whom information was available was a history of such a procedure elicited. This is compatible with the report of Durack that only about 15% of cases of SBE have history of dental work within the previous six months.[2] However, it is apparent that only 11 of 41 (27%) individuals who underwent dental or other procedures were thought to have received any form of antibiotic prophylaxis for the prevention of SBE, while 25 of 41 (61%) were known not to have received prophylaxis.

These findings support the concept that, while many cases of SBE do not apparently follow obvious dental or surgical procedures and therefore are not amenable to prophylactic antibiotic coverage, up to one third of SBE cases may follow such procedures. This, of course, relates to the original observation in 1935 of the association of bacteremia with dental manipulation.[4] The finding that no prophylactic antibiotics were administered in at least 60% of SBE cases preceded by an operative or dental procedure suggests that further educational efforts directed at patients with cardiac disorders and their dentists and physicians should be carried out. Thus, the possibility exists that up to 25 of the 134 cases of SBE (or 19%) reported by the Fellows of the American College of Cardiology may have been prevented by appropriate SBE prophylaxis.

The Committee on Rheumatic Fever and Bacterial Endocarditis of the Council on Cardiovascular Disease in the Young of the American Heart Association has recently published revised guidelines for the prevention of bacterial endocarditis.[5] Copies of this statement (71-005-B, 8-77-200M) are available from local offices of the American Heart Association, Florida Affiliate, and have been mailed to the membership of the Florida Dental Association by the Florida Task Force on Rheumatic Fever and Rheumatic Heart Disease. These guidelines are summarized below.

Summary of Guidelines

For Dental Procedures and also for Tonsillectomy, Adenoidectomy, and Bronchoscopy

I. For most patients: **Penicillin**

a) **Intramuscular:**
Adults: 600,000 units of procaine penicillin G mixed with 1,000,000 units of aqueous crystalline penicillin G 30-60 minutes prior to procedure, followed by 500 mg phenoxymethyl penicillin (Penicillin V) p.o. every 6 hours for 8 doses.
For Children Under 60 lbs: 30,000 units/Kg aqueous penicillin G plus 600,000 units of procaine penicillin, followed by 250 mg phenoxymethyl penicillin every 6 hours for 8 doses. (Not to exceed adult dosage.)

b) **Oral:**
2.0 gm of phenoxymethyl penicillin 30-60 minutes prior to procedure and then 500 mg every six hours for 8 doses. For children under 60 pounds, oral dosages should be reduced by half.

II. For those allergic to penicillin or for those receiving oral rheumatic prophylaxis: **Erythromycin**

Adults: 1.0 gm orally one and one-half to two hours prior to procedure and then 500 mg every six hours for 8 doses.
For Children Under 60 lbs: 20 mg/Kg orally one and one-half to two hours prior to procedure and then 10 mg/Kg every six hours for 8 doses (or Regimen IV).

III. For those patients at higher risk of infective endocarditis (especially those with prosthetic heart valves) who are not penicillin-allergic: **Penicillin** *plus* **Streptomycin**

Adults: IM Penicillin as outlined above in 1a, **plus** Streptomycin 1.0 gm IM, both given 30-60 minutes before procedure; then phenoxymethyl penicillin 500 mg orally every 6 hours for 8 doses.
For Children Under 60 lbs: Timing of doses is same. Aqueous penicillin dose is 30,000 units/Kg mixed with 600,000 units procaine penicillin. Streptomycin dose is 20 mg/Kg.

Oral phenoxymethyl penicillin dose is 250 mg every 6 hours for 8 doses. (Not to exceed adult dosage.)

IV. For high risk patients who are allergic to penicillin: **Vancomycin**

Adults: Vancomycin 1 gm IV over 30-60 minutes, begun 30-60 minutes before procedure; then erythromycin 500 mg orally every 6 hours for 8 doses.

IV and **Erythromycin** orally	**For Children Under 60 lbs:** Timing of doses is same. Dose of Vancomycin is 20 mg/Kg. Dose of erythromycin is 10 mg/Kg every 6 hours for 8 doses. (Not to exceed adult dosage.)

For Gastro-Intestinal and Genito-Urinary Tract Surgery and Instrumentation And also for any Surgery of Infected Tissues

I. For most patients: **Penicillin** or **Ampicillin** *plus* **Streptomycin** or **Gentamicin**	**Adults:** 2 million units of aqueous penicillin G IM or IV or 1.0 gm Ampicillim IM or IV **plus** Gentamicin (1.5 mg/Kg—up to 80 mg) IM or IV or Streptomycin 1.0 gm IM. This should be given 30-60 minutes before procedure. Repeat every 8 hours for two doses if Gentamicin is used, or every 12 hours for two doses if Streptomycin is used. **For Children Under 60 lbs:** Same timing of medications as above. Dosages are aqueous penicillin G 30,000 units/Kg; Ampicillin 50 mg/Kg; Gentamicin 2.0 mg/Kg; Streptomycin 20 mg/Kg. (Not to exceed adult dosage.)
II. For patients suspected to be allergic to penicillin **Vancomycin** *plus* **Streptomycin**	**Adults:** 1.0 gm Vancomycin IV given over 30-60 minutes **plus** 1.0 gm Streptomycin IM, each given 30-60 minutes before procedure. Doses may be repeated in 12 hours. **For Children Under 60 lbs.** Timing as above. Doses are Vancomycin 20 mg/Kg and Streptomycin 20 mg/Kg. (Not to exceed adult dosage.)

NOTE: IN PATIENTS WITH SIGNIFICANTLY COMPROMISED RENAL FUNCTION, ANTIBIOTIC DOSAGES MAY NEED TO BE MODIFIED.

Approved by: Cardiopulmonary Disease in the Young Committee and the Florida Task Force on Rheumatic Fever/Rheumatic Heart Disease. Adapted from: The Report of the Committee on Rheumatic Fever and Bacterial Endocarditis, American Heart Association; Circulation (56: 139A, 1977) 7/78

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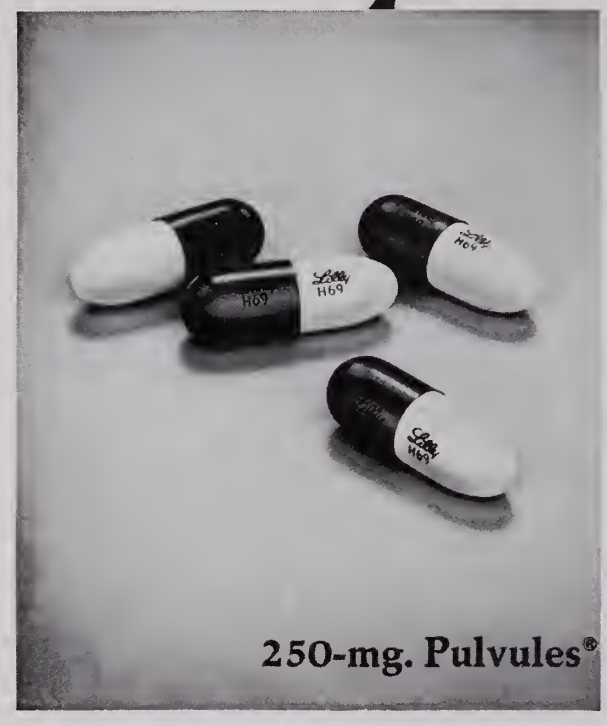
EDITORIAL COMMENT ..... By Charles P. Craig, M.D.

The report prepared by Dr. Shulman for the Florida Task Force on Rheumatic Fever and Rheumatic Heart Disease makes a number of important points. The frequency of infective endocarditis reported by the responding institutions and physicians comes as no surprise; however, it is surprising and disappointing that the reply rates from hospitals and members of the American College of Cardiology in Florida were so low. These low rates (48% and 26.1%, respectively) reflect poorly on the social consciousness of the non-responders. One would hope that this is a poor measure. In addition, the frequency of endocarditis among the responding hospitals (one case per approximately 4,500 admissions) and the absence of reported cases from 59 smaller hospitals with a range of admissions from 1,500 to 13,300 suggests that perhaps cases of endocarditis were overlooked in those hospitals. One would have expected an average of one case from each of those hospitals based upon the statewide average. Whether, if this is correct, the discrepancy is due to underdiagnosis by physicians or errors in medical recordkeeping is impossible to determine. However, one might encourage these institutions to look more carefully for endocarditis in their patients.

On the latter topic, it would be appropriate for medical record librarians to actively discourage the use of the outdated term "subacute bacterial endocarditis" since it is not a useful clinical designation and is inconsistent with the current medical records coding system. Perhaps the most important feature of the study is its discovery that prophylactic antibiotics are so often overlooked when patients with pre-existent valvular disease undergo surgical procedures. Members of the study committee are to be congratulated for raising this important issue since use of the recommended antibiotics might prevent up to 20% of the episodes of infective endocarditis in the state. It is important for all physicians and dentists to be aware of the guidelines for prevention of bacterial endocarditis published by the American Heart Association.

Dr. Craig is Professor of Medicine and Chief, Infectious Diseases at the University of South Florida College of Medicine, Tampa.

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SPECIAL ARTICLES

Your Future

Theodore Cooper, M.D.

I congratulate the men and women of the class of 1978 and your spouses, children, friends and particularly your parents, and I exhort you to think positively as you enter a new level of personal, professional and public responsibility. You have ahead of you tremendous opportunities: to treat the sick, prevent disease, conduct research, teach, learn, build, and to improve the health of the people and health care capabilities of your communities. There are even opportunities to get rich. You have but to choose!

It might seem to some that I am departing from reality in taking a naive, Polyannish approach. It is idealism and idealism is supposed to be out of fashion, if not dead, particularly in the health field. Economists, planners, and regulators are convincing the people and their elected representatives that "health is big business," a business which this year will handle $160 billion and employ over five million people. They point out that it is a growing business which is likely to double in size within a decade or less. Growth is assured because more people will seek more services, and this has been expressed already as a social and political goal. So business must be business, and business is not idealism — but realism. "The bottom line" is what is supposed to count. Besides, some leaders in the health professions claim that health care is scientific and science is facts and facts and romantic old humanistic notions do not mix. They would seem to be saying that modern health care is scientism applied to the human species; that we no longer need the personal services of compassionate practitioners of the healing arts; that what we need is systems designed by social engineers.

I hope you do not accept this view of what your life is to be. I want you to believe that there is a difference between business and the delivery of health care, and that there is a difference between the practice of science and the service to people.

Bigness, complexity, centralized regulation, coupled with current sociological conceptions of delivery of care and the concerns about the insensitivity of science have resulted in a growing list of limitations as to what you can choose to do; therefore, I want you to stand with those who venerate freedom of choice rather than a chance to make money. I will concede at the outset that choice is never completely "free" in any society. By participating in and benefiting from joint action, we always yield some of our individual rights; however, the strength of the American system is that we have recognized the importance of limiting the amount of freedom which we are willing to yield to the federal government.

There are two circumstances in which we tend to delegate to the government more determination of our individual choices than we ordinarily would. The first occurs when the independence (or security) of the nation is in real or alleged jeopardy. The second occurs when the values of the citizens of the nation are strained by too much (affluence) or too little (depression), and rarely do we take back what has been given away. As a consequence, we are building into our way of life a dependency which is beginning to erode compassion, conscience, courage and, yes, even competence.

To illustrate: A call for a new federal social program, when we have not responded as neighbor or friends, is not compassion — it is self-protectionism. A call for governmental regulations, when we have not done the obvious self-governance, removes the need for conscience. Regulations serve as the moral code. A call for federal standards, when we have fantastic opportunities for the achievement of and maintenance of

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This Commencement Address was delivered before the graduating class at the University of Florida College of Medicine, May 26, 1978.

Dr. Cooper is Dean, Cornell University Medical College, New York.

excellence, insures that each of us need only have the incentive for the lowest and common level of competence. A tendency to regard the government as master rather than servant when, in fact, it is supposed to serve the citizenry reduces even distinguished scholars to pandering sycophants without the courage to tell the emperor that he is naked.

There are three areas where you will recognize a call for further delegation by you of your individual freedom. They are known by the rubrics; energy, public welfare and health care. I will comment mainly on the health care issue today. It is different from the others only in that it excites a higher degree of righteous indignation because of the mystique of medicine and the grave misconception that the practice of the health professions is the principal determinant of the status of health of the American people.

On a general basis, the health of the American people is good and is getting better. Last year at the order of Congress, the U.S. Public Health Service reported in a volume entitled, "Health Status, United States — 1976-77," data on all kinds of indices of health: longevity, mortality rates, morbidity, functional capacity, hospitalizations, disabilities, and so on, for all segments of society by age, sex, race and so on.

Death rates have never been lower. More people are living longer. There is even steady improvement in infant mortality rates. Even heart attack deaths are beginning to decline. Cancer shows increase; occupational pulmonary disease, suicide, some other forms of societal-mental health problems, alcoholism and drug abuse show increase.

More disadvantaged — the poor, racially avoided, ethnically stigmatized, geographically isolated, politically abused — are getting more and better health services. Greater percentages of public resources are going into real service for these people.

But one might think that with reports on Medicaid mills, unnecessary surgery, increased costs, fraud, complaints of selling medical school admissions and allegations that the technological practice of today is not doing anything for the health of the people that the public would be disenchanted with our medical care system. Contrary to that view, recent studies on consumer satisfaction with their health service indicate that the public is satisfied with this service. The Robert Wood Johnson Foundation's Special Report No. 1 for 1978 summarizes an extensive survey on access to medical care. Among those who saw a physician in a 12-month period, 88% were satisfied with the overall visit to the doctor; 87% were satisfied with the quality of care provided; 84% were even satisfied with the time spent with the doctor; 92% were satisfied by the courtesy and consideration of the physician. One could not draw these conclusions from what one hears or reads in the news media. It was of interest that the highest rate of dissatisfaction was with the out-of-pocket cost of the care (37%) and the time spent waiting to see the doctor (28%). The study showed, paradoxically, that 61% (despite their satisfaction) believe there is a "crisis," another 26% are uncertain.

There are serious deficiences in our services and in the distribution of services. Much more needs to be accomplished and we need to overcome a tremendous amount of ignorance through research and education; nevertheless, one cannot conclude that the American system has failed, or that American health and medical care are poor. For those of you whose lips curl at this positive assertion, let me remind you that a disparity of capacity in relationship to demand is not a judgment of quality, and that the disparity generates much more from demand and, candidly speaking, a demand which more often than not expresses want rather than need. As the standard of living increases, wants become needs with deceptive speed. For this aspiration and expectation, providers and consumers are responsible. It is as if we have come to believe that more is necessarily better. It is as if we have come to endorse the principle best expressed by that great American philosopher, Mae West, who said, "Too much of a good thing is wonderful!"

The health status of the American people in 1978 is not principally determined by the performance of health care and medical care providers but by economic factors — employment, nutrition, housing and social factors; educational levels and communications systems, the media and cultural factors such as discrimination. Because we want better health and care for more people, let us not choose to achieve it by trying to force more people to do that which they do not wish to do.

If you are impatient with the disparity and shortcomings, fine — it will drive you to action for there is much to do. If you want others to choose what you call the "right thing," work within your homes, families, institutions, and local communities to restore confidence in the self and local social structures to solve problems. Education is one key; new knowledge derived from research is another; perseverance is the third. Simplistic, flamboyant, expensive, inefficient, politically attractive solutions should be replaced by steady realistic cost-effective work. Beware of those who equate parity with progress.

This is a politically active time in the health affairs of the nation. Virtually every call for action sounded in Washington is for the development of some sort of national health policy and national health insurance — reflecting the contention that we do not have either. We do have a policy — it is written in law, P.L. 93-641, that

the national goal is to provide access to quality care at reasonable cost. We have about 200 programs with overlapping authorities designed to achieve the worthy goal and there are thousands of regulations specifying what to do and not to do. Fifty billion public dollars are spent in those programs. Expansion of federal insurance programs will double the public expenditures. Inefficiency in present programs is the subject of investigations and public hearings; bureaucrats are berated for insensitivity. Physicians and hospitals are pictured as greedy beneficiaries of inadequate programs. The remedy is then mandated — more of the same. People want to think that the government can make you well for free.

Nobody gets something for nothing. You pay a price for everything in dollars and in freedom, i.e., subsidization of medical education is no longer good in itself in the national interest. Research support is not justified just because we are woefully ignorant. Expanding input of federal dollars means expanded control of all activities. Professor Julius Comroe of California said it better. He said that the Golden Rule now means he who has (or gives) the gold makes the rules. When someone opts to have someone else make the rules, he or she loses the freedom to choose.

There is now one issue that is inviting further intrusion into your freedoms. It is the escalation of expenditures in the health system at a rate greatly in excess of general inflationary trends. Mind you, it is not the only item with a rate of change greater than that of the average CPI; however, it is large and as a consequence instant experts are again proposing more regulations as the way to solve the problem — regulation of incomes and prices, practices in hospitals, what procedures can be done, what kind of research should be done.

Very well, you might be thinking, if you are not just resting your eyes, what can I do about this? These complex problems have stymied experts — even from the Northeast, even from Washington!

I suggest five things not to do and five things to do. The do not's:

Do not lose your nerve — have an opinion, make decisions!

Do not lose you imagination — nothing is impossible!

Do not lose your idealism — there is great love left in the world.

Do not lose your intellectual independence — you really do not have to agree with every committee report from Washington or even everything you were told at the university.

Do not lose your self-confidence — you have proven you can handle it.

The do's:

Recognize your responsibility to set the pace in the system — your actions will determine your future opportunities.

Be willing to sacrifice personally your greatest economic potential in order to maintain the freedoms you have left.

Participate in meaningful programs for the self-governance of your profession — be your brother's and sister's keeper!

Become leaders in your community efforts to allocate available public resources for health activities — do it in a just and fair manner.

Communicate, explain, take your message and your case to the public and say what you mean — in plain talk.

Do not be like the gentleman with a thirst, temporarily embarrassed for funds, who sought free drink at the local bar by demonstrating the remarkable ability of his canine companion to talk to humans. The skeptical barkeeper said, "Show me and the drink is yours." So our friend asked the dog, "What covers a house?" and the dog said, "Ruff" (roof). The bartender scowled, "Are you kidding?" The thirsty gentleman asked again, "Who was the greatest Yankee baseball player?" to which the dog answered, "Ruff" (Ruth). Following which both were ejected from the bar, and as they picked themselves up with dignity, the dog turned to the gent and asked, "Do you think I should have said Joe DiMaggio?"

Your profession is dedicated to the service of humanity. To serve people you must communicate with them. You must recognize that poor service results more often from inadequate understanding than from technological deficiency.

Finally, you have to believe — the future is to be made. It is a future with promise of even better tools to help the sick get well and to help the healthy stay well. The public already believes — they believe in that future — and they believe in you.

May you all succeed and enjoy success!

● Dr. Cooper, Cornell University Medical College, 1300 York Avenue, New York 10021.

One half of knowing what you want is knowing what you must give up before you get it.

Sidney Howard

Medicine Obeys the Law

Fred O. Smith, M.D.

Abstract: The law of supply and demand is discussed. Physician "supply" numerically continues to rise, but federal requirements lower the actual time available to patients. The concept of varying markets for different specialties is introduced. The demand for physician services is stimulated by multiple factors and continues to rise faster than supply. This demand increase pushes the price upward. The application of the law of supply and demand to the practice of medicine is reaffirmed.

We have all heard that "the law of supply and demand does not apply to medicine." In the tradition of oft-repeated falsehoods, such statements are being accepted without question by physicians and bureaucrats alike who do not understand the law of supply and demand. The observation has been made that the number of physicians has increased, both nationally and in many urban centers. The cost of physicians' services continues to rise, even after discounting the inexorable inflationary devaluation of the American dollar. I contend that it is precisely because of the law of supply and demand that physician prices continue to rise.

The law of supply and demand is straightforward. In a free and unrestricted market, the price of a uniform, homogenous product produced by a large number of equal sellers will rise if the demand by a number of equal buyers goes up. The price of a uniform homogenous product will also rise if the demand holds constant but the supply is diminished. For example, when a sudden freeze lowers the supply of lettuce, continued demand will cause a price rise. At the higher price, demand drops causing a fall in the price. Thus, the law of supply and demand can work to either raise or lower prices. Each factor — supply, product, market and demand — will be discussed separately.

Supply

The supply of physicians is increased by graduates of United States medical schools and by graduates of foreign medical schools who enter our country. In each state the supply is controlled by state licensing boards which set requirements for applicants. While established to protect the inhabitants from the poorly trained physician, they function in reality as the only political barrier to interstate migration. The supply of physicians can be lowered by death, emigration, or early retirement. The supply of physicians can also be lowered by removing them from patient care, either through full-time administrative positions or part-time through required participation in nonproductive activity. Postgraduate medical education requirements, which many physicians consider to be of dubious benefit in improving patient care, still decrease the supply by removing the physician from his patients. In the hospital with which I am most familiar, each physician on the active medical staff is required to attend four committee, department and staff meetings monthly, each meeting lasting one hour. These meetings satisfy J.C.A.H. requirements but lower the supply of physicians to the community during this time. In addition, hospital staff leadership positions, while being great honors, are also great time consumers. A conservative estimate of four hours extra duty per month for each office, in addition to the committee and staff meetings, is not unreasonable. For our staff of 80 physicians, 400 physician hours or more per month may be spent during the working day at other than patient care. This is the equivalent working time of two primary physicians.

I practice in an area of rapid population growth on the Gulf Coast of Florida. The physicians in this area have resisted the establishment of local PSRO's so that no physician time is absorbed locally through this institution. For the future, however, this looks to be an extremely efficient open-ended bureaucratic tool for absorbing physician time (and thereby decreasing physician supply). The cost effectiveness of PSRO remains controversial, but its absorption of salaried physician time is undisputed. Further, it seems to me that those areas of the nation where physicians have increased in numbers the most, relative to the employed population, are precisely those areas where physicians most vigorously embrace PSRO and its part-time jobs. Thus, although the actual number of physicians may increase, federal programs act to reduce the number of patient care hours available.

Further understanding is achieved with the

From the Department of Family Practice, Mease Hospital and Clinic, Dunedin.

recognition that the "national supply" of physicians is misleading. We operate in largely local markets. The national market is only shopped by the rich, mobile, and informed consumer. The European political figure may fly to Houston for vascular surgery, the New York actress may fly to Los Angeles for cosmetic surgery, but the schoolboy with acne and the butcher with hemorrhoids stay pretty close to home. Indeed, for many segments of our industry such as pathology and anesthesiology, each market may be bounded completely by the property line of its local hospital. The local markets as perceived by the buyer-patient may reflect traditional shopping areas, socioeconomic housing groupings, or geographical barriers, but they are much more narrow than commonly thought. The consumer may travel 100 miles across two counties searching for a bargain in a new car but would never travel that far looking for a cheaper proctoscopy.

The struggle between supply and demand thus takes place on a very narrow pitch. There are even different markets for different services. A single county with five hospitals may have five markets for anesthesiologists, seven or eight markets for family practitioners, but only one market for neurosurgeons and endocrinologists.

Specialization may serve the patient by providing a physician who is better informed about the disease from which the patient suffers. There is no doubt that specialization also serves the physician by lowering the number of sellers for his particular product, thus lowering the supply. A pediatrician, obstetrician, internist, general surgeon, orthopedist, otorhinolaryngologist, and ophthalmologist can all peacefully coexist in an area where one general practitioner bravely, cheaply, although probably less therapeutically, once trod alone. Specialization decreases the number of doctors for any particular service, thus tending to increase the price.

Product

The classic product is homogenous (even though produced by a large number of different sellers) such as apples, celery, or fertilizer. Our product is certainly not uniform and homogenous. We sell largely an intangible service which is difficult to compare among physicians. Even with large numbers of sellers, we strive to individualize our services and thus decrease competition. The appeal of the "country doctor," which was a personal interaction unrelated to scientific skills, made his service unique. A unique service is, by definition, priceless. Thus we fall somewhat short of the classic model in this regard. There is enough patient movement from seller to seller, however, to convince me that our product is sufficiently uniform in the eyes of the buyer to reaffirm the economic law.

Market

Do physicians operate in a free and unrestricted market? I maintain that they do. Physicians are spared many of the restrictions that fetter other service industry entrepreneurs. Just reflect on the restrictions placed upon the owner of the corner bar, or the local taxicab company, or the local ambulance service. As long as the physician pays local, state and federal taxes and is duly licensed, he or she is free — indeed welcome — to establish himself anywhere. In considering markets, we can consider the poor and underprivileged. The cry of "lack of access to health care" may be considered as an economic issue. The disadvantaged are unable to attract physicians to locate in what they consider to be their traditional market places. The underprivileged must, therefore, travel outside their own marketplaces, often on unreliable public transportation. They may turn to less effective practitioners or employ home remedies within their traditional marketplaces. Federal and states moneys subsidize to some extent their entrance into more affluent markets. Some physicians consider our present federal policies to be beginning steps in the enforced empoverishment of physicians, thus forcing us into less rewarding markets. (It is unfair to publicize the health needs of the urban and rural poor. After all, the poor and underprivileged markets are also unable to attract competent teachers, attorneys, craftsmen or merchants to their areas as well.)

Demand

The key to understanding the economics of medicine is this—the demand for physicians' services continues to exceed supply. In this lie all the law and profits[1].

As more physicians enter previously underserved areas (markets) and as public assistance enables new buyers to enter established markets, the demand increases. With new physicians entering the market, there is less moral suasion on the part of the patients to spare "the doctor's valuable time." Increasingly, the physician's services are paid for by federal dollars, more easily spent by the patient than their own, thus raising demand. The slightly ill, worried well, and the well enter the physician's service market in abundance. Each "public service" announcement of the carcinogenic properties of our favorite foods is a stimulus to the demand for our product. Each fund raising drive by an illness-related charity is accompanied by pictures and script designed to arouse our compassion, concern and

generosity. They also increase the demand for our product as the worried well flock for reassurance. Every television talk show and gossip magazine seeking to line its coffers by stimulating sales through health-oriented features also stimulates demand for our products. H.E.W. regulations requiring scheduled reevaluation of patients for therapies and custodial care also increase the demand.

Physicians keep their names before the public by receiving awards, presenting public information forums, or frequenting civic clubs. Scientific assemblies produced by physicians, articles published in leading medical journals, and local medical society educational programs can also increase demand. These are generally acceptable techniques for stimulating referrals (increasing demand).

There are less beneficial ways to foster demand. Those physicians who peddle nostrums or hawk fad diets or unproven cancer therapy foster demand in a manner not beneficial to the public. Demand can be increased by lowering one's criteria for surgery. The unfortunate joke about the possession of a uterus being the sole criteria for hysterectomy reflects our society's concern over this economically logical, but ethically reprehensible technique. The office physician, through increased laboratory utilization, more frequent office return visits, and "ring around the rosey" referrals is also able to increase demand.

In other industries, merchants use advertising to constantly remind the buyer of the availability and desirability of his product. For any public agency to insist on physician advertising is thus to insure a further rise in demand. It is to my mind a credit to the selflessness of my profession (or a recognition that the demand still exceeds supply) that we resist what would obviously increase our business. The rapidly increasing volume of legal advertising may well be a measure of the present over-supply of attorneys. What is good for the sales of General Motors would be good for the sales of medicine as well. Increasing sales, of course, does not necessarily increase the well-being of the individual consumer.

In summary, the physician seller operates in a market similar to the sellers of other services. The demand for our services is still increasing more rapidly than the supply, permitting the price for our services to float upward. I see no slackening of demand in the foreseeable future. The law of supply and demand does indeed apply to medicine.

Reference

1. Parkinson, C.N.: The Law And The Profits.

● Dr. Smith, Mease Hospital and Clinic, Dunedin, Florida 33528.

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The Florida Medical Association established FMA-PLI Trust commenced writing professional liability indemnification on December 1, 1975, and was replaced by the Florida Physicians' Insurance Reciprocal on December 31, 1976 because of the undesirability of the Trust's assessability feature.

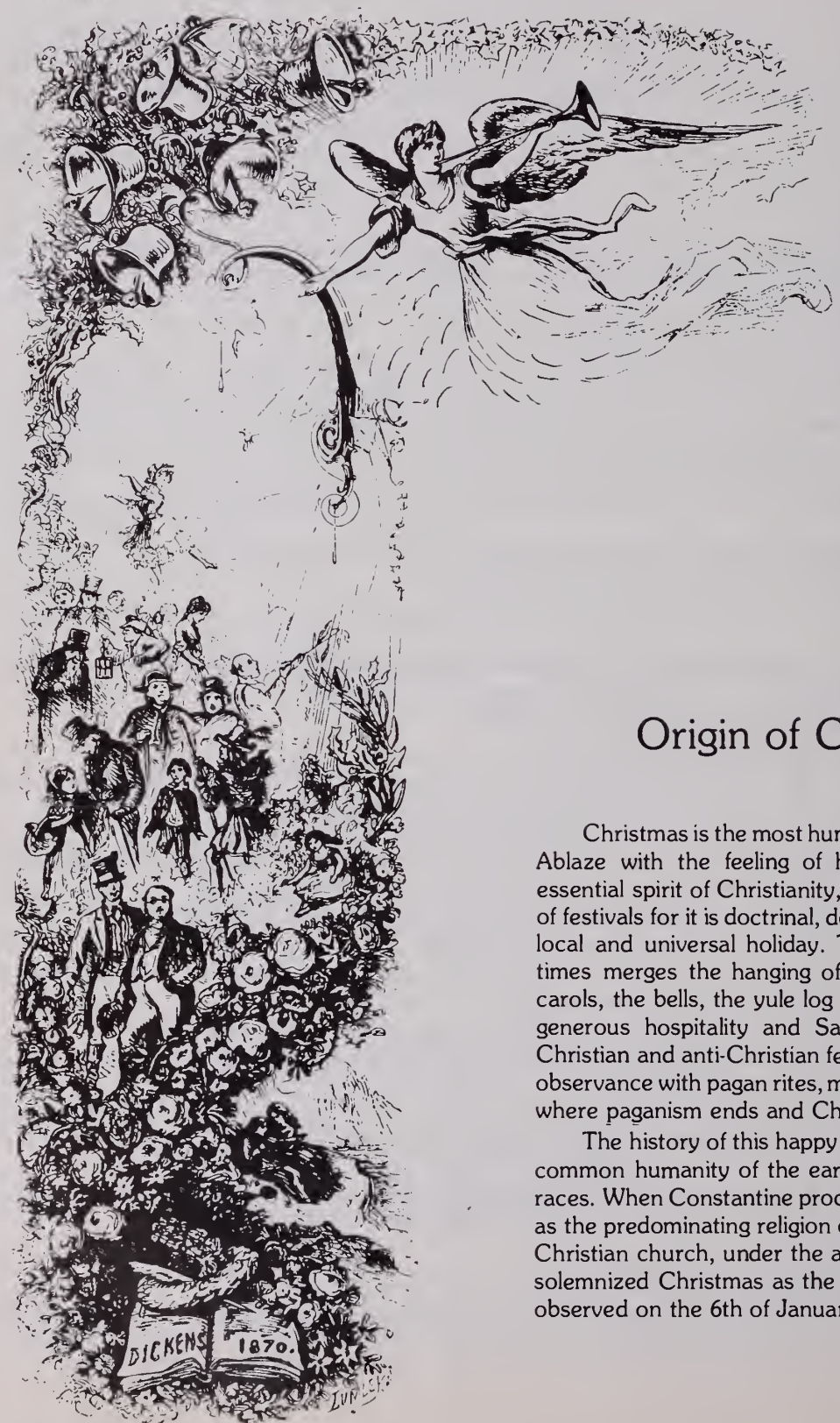
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- The Board of Directors (Advisory Committee) includes the current FMA President, the President-Elect, two past presidents and a member of the Board of Governors.
- is a charter member of the P.I.A.A.—a national association of physician owned-medical society sponsored insurance companies.
- Insures approximately 6,000 physicians, 15% of whom reside in Dade and Broward counties.
- Has approximately 40 million dollars in reserves and other assets.
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- Requires members written consent to settle (an arbitration agreement does exist to settle disputes).
- Provides centralized coordination of legal services and claims review.
- Has established (through PIMCO) its own claims investigative staff located in Jacksonville, Miami, Tampa and Sarasota.
- Has retained Barnett Financial Advisors for all investments.
- All loss reserves, surplus, and unearned premium funds are on deposit in a bank trust department.
- Professional Associations are insured at a premium of 20% of the stockholders premiums (except for solo P.A.'s where there is no charge) to afford additional protection.
- Employed Physician's Assistants and Nurse Anesthetists are endorsed to the employer's policy and are thus protected.
- Had two audits by the Florida Department of Insurance during 1978 to examine the operation and the premiums of the Reciprocal.
- The Reciprocal has minimal overhead expenses and pays no commissions to agents. It is managed by the Professional Insurance Management Company (PIMCO) under a fee for service contract. The Reciprocal's premium dollar during 1978 was utilized as follows:

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The Attorney-in-Fact of the Reciprocal is the Executive Vice President of the Florida Medical Association.

EDITORIAL



Origin of Christmas

Christmas is the most human and kindly of seasons. Ablaze with the feeling of human brotherhood, the essential spirit of Christianity, it is the most ecumenical of festivals for it is doctrinal, dogmatic and theological, a local and universal holiday. This holy day of modern times merges the hanging of mistletoe and holly, the carols, the bells, the yule log and yule candle, prayers, generous hospitality and Santa Claus, blending the Christian and anti-Christian feelings, mingling Christian observance with pagan rites, making it difficult to discern where paganism ends and Christianity begins.

The history of this happy festival is evidence of the common humanity of the earlier and the more recent races. When Constantine proclaimed the Christian faith as the predominating religion of the Roman empire, the Christian church, under the aegis of imperial authority solemnized Christmas as the birth of Christ. Formerly observed on the 6th of January, Christmas was moved

back to the 25th of December, coincidentally the time of the Roman saturnalia, when the early Christians, unable to defend the 6th of January as the date of Christ's birth, adopted the day we now celebrate. This was based on the belief that the conception of the Virgin Mary took place on the anniversary of the day of the creation of the world, the 25th of March, when the days and nights were equal. So, many of the Christmas characters and customs, if not of pagan origin, constitute a curious medley of paganism and Christianity. Curiously enough in Germany, the Christmas holidays replaced the old pagan rites of the twelve nights, December 25th to January 6th. This had been religiously observed by ancient Teutons and Goths believing the active forces of nature to be mythical gods symbolizing the conflict of natural forces in the battle of the seasons. Regarded by the Druids with religious veneration, mistletoe and its berries of pearl white, symbol of purity, was associated by them with the rites of marriage. From this, the transition was but slight to the lover's kiss beneath its mystic bough during the Christmastide. Following the introduction of Christianity into Germany, the evergreen fir, symbolic of eternal springtime, became the Christmas tree and was accepted in religious worship. The burning lights were to honor Him who was the light of the world while the gifts are a reminder that those blessed with many material goods should share with those who have little.

The season's best known personage was born in Lycia, in the third or fourth century and became the Bishop of Myra. Over the years he has become the patron of children the world over and is the most popular saint on the calendar. The Sunder Klass of Holland, the Samiklaus of Switzerland, the Sonner Klas of Helgaland, to children, Santa Claus is the burden of their prayers, the staple of their dreams and the inspiration of their songs. In many countries, children put their shoes around the fireplace with the expectation on Christmas Eve that he will fill them with sweetmeats and toys for good children, but with sticks and rods for the bad ones. Often St. Nicholas was accompanied by angels and in Germany, by Ruprecht, the frightful bugbear, who threatens children who have not been obedient, until the Christ child intercedes for them. Hans Trapp, the Alsatian Ruprecht, dressed in fur and covered with chains, plays a conspicuous part in French Christmas festivals, kidnapping naughty children or threatening them with severe punishment. In Poland, children are told that on Christmas night the heavens open and Jacob's ladder is let down for angels to come to earth but only saints are permitted to see this.

Abolished for a time by parliment in 1647 and outlawed for a while in New England by the puritans, Christmas was brought to New Amsterdam by the Dutch who celebrated it both as an ecclesiastical and a social and domestic holiday.

From the observance of these many pagan traditions, Christian civilization has been the gainer in a more rational observance of the Christmas festivities. Over the world, the Christmas tree today sheds its mellow radiance over a more quiet but nonetheless enjoyable scene. Churches and family sanctuaries robe themselves in evergreen, holly, ivy and laurel. Generous portions of beef, spiced ham and bread, fruit and candies are distributed to the parish poor while Christmas bells ring out their silvery chimes in the morning air, joyfully and cheerfully amongst a spicy flavor of the old time feasting and frolic. Over the centuries, the purifying spiritual fires lit by martyrs and religious leaders have purged the theological and ecclesiastical dross away, leaving the pure gold of faith and human sympathy containing the central truth of Christianity. This is charity, which is love, meaning the spirit of universal brotherhood. While almsgiving, defined as giving of the heart and soul and life to help others, commemorates the birth of the Christ child, so is this a festival of humanity and inspiring sentiment of actual life.

A curious medley of the old and the new; ancient customs, receiving the rites of Christian baptism, have brought the religious thought of all ages and countries into an expression which makes the scriptures of the most divergent nations harmonious. So, from the lovely legends and songs, the birth of a child, mystic rites, pagan lore and quaint customs, to the lighting of the Christmas tree, hanging of stockings, profuse giving, happy gathering of families, the turkey and all its trimmings, Christmas today is the day of days which declares the universal human consciousness that peace on earth comes only from good will to men.

C. M. C.



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Deaths

Berry, James F., Fort Lauderdale; born 1922; George Washington University, 1947; died August 26, 1978.

Biggane, Charles F. Jr., North Miami; born 1921; University of Pennsylvania, 1945; member AMA; died August 26, 1978.

Blackburn, Lester H., Sarasota; born 1917; Louisville Medical School, 1943; member AMA; died October 6, 1978.

Bostic, Sam C., Oklawaha; born 1896; Columbia Medical School, 1928; member AMA; died September 18, 1978.

Briggs, Nevin J., Sarasota; born 1932; University of Freiburg, 1960; member AMA; died September 14, 1978.

Britt, Reddin, St. Augustine; born 1900; University of Georgia, 1926; member AMA; died July 12, 1978.

del Monte, Erasmo E., Plantation; born 1918; Havana University, 1946; died August 1, 1978.

Garner, Wade H. Sr., Sanford; born 1900; University of Maryland, 1927; died July 20, 1978.

Hardin, Marvin S., Tampa; born 1924; Temple University, 1947; member AMA; died July 4, 1978.

Latty, Samuel G., Winter Park; born 1925; Duke University, 1949; member AMA; died August 12, 1978.

McLane, Anthony D., West Palm Beach; born 1905; Georgetown University, 1930; died August 12, 1978.

Purcell, Anthony D., Fort Lauderdale; born 1936; Georgetown University, 1963; member AMA; died April 27, 1978.

Roberts, Thomas L. Jr., Fort Lauderdale; born 1910; Emory University, 1935; member AMA; died July 1, 1978.

Rutter, Joseph H., Daytona Beach; born 1901; University of Maryland, 1928; member AMA; died October 8, 1978.

Simmons, Thomas G., Lakeland; born 1887; University of Tennessee, 1912; member AMA; died August 1978.

Sutter, Leroy M., Orlando; born 1904; College of Medical Evangelists, 1930; member AMA; died September 14, 1978.

Tinkler, Bruce R., Lakeland; born 1890; Physicians & Surgeons Columbia University, 1920; member AMA; died August 15, 1978.

Weems, Nathaniel M. Sr., Boynton Beach; born 1898; Emory University, 1924; member AMA; died September 1978.

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ORGANIZATION

Two Student Editors Are Appointed To Journal Staff



Mr. Merlin



Mr. Baker

The appointment of two new student consulting editors to the staff of *The Journal of the Florida Medical Association* have been announced by Editor Gerold L. Schiebler, M.D.

They are Mr. Tobby L. Merlin, 26, a third-year student at the University of Florida College of Medicine in Gainesville; and Mr. John A. Baker, 23, a second-year student at the University of South Florida College of Medicine, Tampa.

Both are student members of their respective county medical societies and of the Florida Medical Association, and both were nominated for appointment by their medical school deans.

A native of Montana, Mr. Baker moved with his family to Jacksonville in 1965, where he graduated from Edward H. White High School in 1973. He attended Florida Junior College at Jacksonville, and received his B.A. degree with highest honors in June, 1977, from the University of North Florida.

He entered the University of South Florida College of Medicine in July 1977 and was designated a New York Life Medical Scholar. His favorite recreational pursuit is raquetball, and he aspires to a career in internal medicine.

Mr. Merlin was born in Atlanta, Ga., and earned a Phi Beta Kappa key at Yale, where he graduated in 1974. He has been an officer of the American Medical Student Association and is an officer of his 1980 medical school class.

Prior to entering medical school, Mr. Merlin worked as an extern in medical facilities in Austria and West Germany. An outdoorsman, he enjoys hiking, skiing and white water rafting.

The new appointees bring to four the number of medical students on the editorial staff. Mr. Richard Snyder of the University of Miami School of Medicine and Mr. Jerrold Van Dyke of the University of Florida College of Medicine are serving as Assistant Editors.

President Davenport Appeals for AMA Membership Boost

Florida may lose some of its voting strength in the American Medical Association House of Delegates unless some 300 Florida physicians join or rejoin AMA by year's end.

In a memorandum dated October 20, FMA President O. William Davenport, M.D., said Florida will lose one of its seven AMA delegates unless the State's AMA membership reaches at least 6,001 by December 31. On September 13, membership was 299 short of that mark.

Dr. Davenport's memorandum was circulated to physicians who had not renewed their AMA membership this year. He appealed to them to renew at once.

"Florida has increasingly become a highly influential and well-respected state in the AMA's House of Delegates," Dr. Davenport said. "It would be tragic to diminish this influence, particularly at such a crucial time when the issues facing organized medicine are so overwhelming in their potentially disastrous effects on the future of the private practice of medicine."

Annual Meeting Scientific Program Continues to Take Shape

Several additional scientific programs have been announced for the 105th Annual Meeting of the Florida Medical Association.

The meeting will be conducted Wednesday through Sunday, May 23-27, at the Diplomat Hotel in Hollywood.

Florida's three medical schools have agreed to co-sponsor the scientific program, according to Calvin W. Martin, M.D., of Arcadia, Acting Chairman of the Scientific Program. Application will be made to the Medical Education Committee of the Florida Medical Foundation for certification of Category I Credit.

The following programs have been announced in addition to those listed in the November issue of *The Journal of the Florida Medical Association:*

WEDNESDAY AFTERNOON — MAY 23
SECTION ON CANCER AND NUTRITION
(Co-sponsored by Florida Society of Clinical Oncologists, Florida Academy of Family Physicians, and FMA Ad Hoc Committee on Nutrition)
Wednesday — 1:30 p.m. to 4:00 p.m.
Phillip C. Smith, M.D., Boca Raton
Program Chairman

Keynote Address: "The Role of the Government in Identifying and Controlling Carcinogens in the American Diet" (Speaker to be Announced)

"Nutrition and Patients' Response to Cancer Therapy," Edward M. Copeland III, M.D., Professor of Surgery, University of Texas, Houston, Texas.

"The Spectrum of Nutritional Deficiencies in the Patient with Cancer," Everett V. Sugarbaker, M.D., Associate Professor, Department of Surgical Oncology, University of Miami School of Medicine, Miami.

"Parenteral Methods of Nutrition," Edward M. Copeland III, M.D., Houston, Texas.

FRIDAY MORNING — MAY 25
SECTION ON NUCLEAR MEDICINE
(Co-sponsored by Florida Association of Nuclear Physicians)
Friday — 8:00 a.m. to 10:30 a.m.
Marvin Guter, M.D., Miami
Program Chairman

(Note: The program for this Section will be presented first in Spanish, then in English)

"Gamagrafia Cardiaca: Metodo no Invasivo de Descarte en Enfermedad Coronaria," Ernest Garcia, Ph.D., Assistant Professor of Radiology, University of Miami School of Medicine; and Division of Nuclear Medicine & Ultrasound, Jackson Memorial Hospital, Miami.

"Gamagrafia Biliar y Ultrasonido," Dino Morello, M.D., Instructor in Radiology, University of Miami School of Medicine; and Division of Nuclear Medicine & Ultrasound, Jackson Memorial Hospital, Miami.

"Nuclear Cardiology: Non-Invasive Screening for Coronary Artery Disease," Ernest Garcia, Ph.D., Miami.

"Biliary Nuclear Medicine and Ultrasound," Edward Eikman, M.D., Associate Professor of Medicine, University of South Florida College of Medicine; and Veterans Administration Hospital, Tampa.

FRIDAY AFTERNOON — MAY 25
SECTION ON COLON AND RECTAL SURGERY
(Co-sponsored by Florida Society of Colon and Rectal Surgeons)
Friday — 1:30 p.m. to 4:30 p.m.
Walter W. Hamilton, M.D., St. Petersburg
Program Chairman

"Sigmoid Diverticulosis—New Concepts," Rupert B. Turnbull, Jr., M.D., Senior Colon and Rectal Surgeon, Department of Colon and Rectal Surgery, Cleveland Clinic, Cleveland, Ohio; and Member, Santa Barbara Medical Foundation Clinic, Santa Barbara, Calif.

"Thrombosed External Hemorrhoids: Treatment with Cryotherapy and Surgical Drainage," James Barron, M.D., Colon and Rectal Surgeon, Boca Raton, Fla.; and James Robert Barron, M.D., Resident in Surgery, Ochsner Clinic, New Orleans, La.

"Interstitial Radiation for Selected Anal Carcinomas," Rupert B Turnbull, Jr., M.D., Cleveland, Ohio.

Panel on Ano-Rectal Surgery

Moderator: Shed H. Roberson, M.D., Colon and Rectal Surgeon, Daytona Beach.

"Anal Ulcers and Difficult Anal Stenosis," Romel DeMorais, M.D., Colon and Rectal Surgeon, Tampa.

"Extensive Acute Hemorrhoidal Disease," Sergio Larach, M.D., Colon and Rectal Surgeon, Orlando.

"Acute Rectal Suppurations," Harvey Shub, M.D., Colon and Rectal Surgeon, Orlando.

SATURDAY MORNING — MAY 26
SECTION ON CLINICAL ONCOLOGY
(Co-sponsored by Florida Society of Clinical Oncologists)
Saturday — 9:00 a.m. to 10:30 a.m.
Phillip C. Smith, M.D., Boca Raton
Program Chairman

Introduction — Phillip C. Smith, M.D., Boca Raton.

"Colorectal Carcinoma," Leonard Gunderson, M.D., Assistant Professor, Harvard Medical School, Boston, Mass.

Discussion

"Carcinoma of the Pancreas," Robert Kaplan, M.D., Chief, Department of Oncology, Division of Gastroenterology, University of Miami School of Medicine, Miami.

Discussion

SECTION ON NEUROLOGY
(Co-sponsored by Florida Society of Neurology)
Saturday — 8:00 a.m. to 12:00 noon
Jacob Green, M.D., Jacksonville
Program Chairman

"Quality Control in EEG—A National Need," Eric Gibbs, M.D., Chicago, Ill.

"Dopler Scanning System for the Noninvasive Discovery of Extra Cranial Carotid Disease or Stroke Screening," M. W. Kilgore, M.D., Jacksonville.

"Brain Stem Auditory Evoked Potentials, Visual Evoked Potentials and Other Far Field Responses" or "Wave of the Future," Vinod Deshmukh, M.D., Jacksonville.

Roundtable Discussion.

SECTION ON UROLOGY
(Co-sponsored by Florida Urological Society)
Saturday — 9:00 a.m. to 10:30 a.m.
Roy P. Finney, M.D., Tampa
Program Chairman

Milton Coplan Pyelogram Hour

SECTION ON PHYSICAL MEDICINE AND REHABILITATION
(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation
Saturday — 10:00 a.m. to 12:00 noon
Hector A. Freytes, M.D., Miami
Program Chairman

"International Rehabilitation," Sidney Licht, M.D., Past President, American Congress of Physical Medicine, Coral Gables.



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SPONSORSHIP

The First Annual Walt Disney World Pulmonary Wintercourse is co-sponsored by the Florida Thoracic Society, the University of Florida College of Medicine, the University of Miami School of Medicine, the University of South Florida College of Medicine, and the Florida Lung Association.

COURSE ACCREDITATION

As an organization accredited for continuing medical education, the American Thoracic Society certifies that this continuing medical education activity meets the criteria for 28 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

For Information Contact:
Asher Morks, M.D.
Florido Thorocic Society (904) 743-2933
P.O. Box 8127
Jocksonville, Florido 32211

Dr. Edward W. D. Norton To Head Academy of Ophthalmology



Dr. Norton

Edward W. D. Norton, M.D., Professor and Chairman of the Department of Ophthalmology at the University of Miami School of Medicine, has been designated President-Elect of the American Academy of Ophthalmology. Elected on October 23 at the Academy's business meeting in Kansas City, Mo., Dr. Norton will take office as President in January, 1980.

A nationally-known ophthalmologist, Dr. Norton is Medical Director of Miami's Anne Bates Leach Eye Hospital and the Bascom Palmer Eye Institute. He has served as Chairman of the American Board of Ophthalmology and currently is a member of the National Advisory Eye Council of the National Eye Institute.

The new President-Elect is a native of Somerville, Mass. He received his B.A. degree from Harvard and his M.D. from Cornell University Medical School in 1946. He served a residency in ophthalmology at New York Hospital — Cornell Medical Center in New York City; and served as a research fellow at Howe Laboratory, Boston; Massachusetts Eye and Ear Infirmary; Wilmer Institute of Ophthalmology, Baltimore; and the Mayo Clinic, Rochester, Minn.

Another Floridian, Melvin L. Rubin, M.D., of Gainesville, was elected Secretary for Instruction of the Academy.

Members voted to incorporate as the American Academy of Ophthalmology, effective January 1, 1979. The action terminates the former American Academy of Ophthalmology and Otolaryngology, which dates back to 1896.

Insurance Commission Conducts Hearing On Standard Claim Form

At the request of the Florida Medical Association, State Insurance Commissioner Bill Gunter conducted a public hearing in Tallahassee on October 23, 1978 regarding implementation of a 1977 law enacted by the Florida Legislature requiring that the Department of Insurance prescribe a standardized health claim form to be used by all physicians.

The FMA presented testimony at the hearing in support of allowing attachments, provided the attachment contains all the necessary information required on the standardized form.

FMA members will be advised of the final ruling made by the Insurance Department regarding the use of a standardized claim form at the earliest possible date. Implementation of the law will be delayed pending a final ruling by the Department.

Background

The Florida Legislature enacted FS Chapter 77-46 requiring the Department of Insurance to prescribe a standard health form to be used by all hospitals and a standard health claim form to be used by all physicians and pharmacists. These forms shall be accepted by all insurers and the Department of Health and Rehabilitative Services. (This Act does not apply to claims submitted by electronic or electro-mechanical means.)

The law became effective on January 1, 1978 and the regulations were to become effective July 1, 1978. The Insurance Department has adopted the "Health Insurance Claim Form" approved by the American Medical Association as the form which shall be utilized for physicians claims.

Representatives of the FMA requested the Insurance Department to allow attachments and to delay implementation to provide physicians adequate time to obtain the appropriate forms and to provide for an orderly transition. The Department, citing the specificity of the law, ruled that no attachments would be allowed with the exception of a signature authorization.

The Insurance Department did recognize that implementation of this law without utilization of attachments would cause some physicians and their patients hardship. The Department authorized a transition period until October 1, 1978, during which time attachments could be utilized to the Standard Health Claim Forms. After that period of time no attachments would be permitted with the exception of a signature authorization attachment where the patient's signature cannot be shown, such as in the case of a computerized operation. The Department of Insurance indicated that a notice would be sent to companies affected by this ruling. FMA subsequently requested and was granted a public hearing in order that testimony supporting FMA's request that attachments be allowed might be presented.

Doctor, Please Remind Your Wife

The holiday season is in sight and most physicians' wives are already planning menus, making decorations, and anxiously anticipating family reunions during the holidays.

However, there is a small group of physicians' wives who are projecting plans beyond the merriment of 1978. The FMA-A Convention Committee has Phase I on the drawing board for the "Best Ever" Annual meeting.

The site is the newly-redecorated, under new and better management, Diplomat Hotel, Hollywood, Florida and the dates are May 23-27, 1979.

The required business of the House of Delegates will be expeditiously handled so that sufficient time for relaxation will be available. The Art Show, Awards, Past Presidents and FLAMPAC luncheons will not only provide enjoyment but will add political insight.

Your spouse will be hearing from us personally and we ask you to encourage her attendance. The Auxiliary's goal is to assist you, but we can only be as effective as our numbers and interests indicate. YOU, Sir, can be a catalyst for our success.

Bennie Spanjers (Mrs. Arnold J.)
Convention Chairman,
FMA-A 1979

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ANNOUNCEMENT

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January 26, 1979

For Further information call:
Oscar S. Cunanan, M.D.
Coordinator
(305) 891-3350

CONFERENCE NAME:	**ELEVENTH TEACHING CONFERENCE IN CLINICAL CARDIOLOGY**
EMPHASIS:	Problems commonly seen by PRIMARY CARE PHYSICIANS including Bedside Diagnosis, Coronary Artery Disease, Hypertension, Valvular Heart Disease, and Current Concepts in Therapy.
SPECIAL FEATURES:	THE CARDIOLOGY PATIENT SIMULATOR (ANIMATED MANIKIN) will be used extensively to present a variety of "patients" including all bedside findings, arterial & venous pulses, precordial movements and auscultation. All will participate through audiophones and closed circuit TV. Also: ECG, echocardiography and patient management workshops; Current status of scintigraphy, stress testing and rehabilitation; Practical treatment of angina, infarction and failure; Recognition of risk of sudden death; Abstracts and Self Assessment questions; Self-Learning Laboratories; Luncheon lectures.
GUEST PROFESSORS:	Robert O. Brandenburg, M.D., Prof. of Medicine, Division of Cardiovascular Disease, Mayo Clinic, Vice Pres., American College of Cardiology; Joel M. Felner, M.D., Assoc. Prof. of Medicine, Emory University School of Medicine, Dir., Coronary Care Unit and Non-Invasive Laboratory, Grady Memorial Hospital, Teaching Scholar, American Heart Association; Adolph M. Hutter, Jr., M.D., Assoc. Prof. of Medicine, Harvard Medical School, Assoc. Dir., Coronary Care Unit, Massachusetts General Hospital; Andrew G. Wallace, M.D., Prof. of Medicine, Chief, Division of Cardiology, Duke University Medical Center.
COURSE APPROVAL:	As an organization accredited for Continuing Medical Education, the University of Miami School of Medicine certifies that this Continuing Medical Education offering meets the criteria for 32 prescribed hours by the American Academy of Family Physicians.
SPONSORED BY:	The University of Miami School of Medicine and the Council on Clinical Cardiology of the American Heart Association.
DATES:	February 28 to March 3, 1979.
LOCATION:	The Americana Hotel of Bal Harbour, 9701 Collins Ave., Miami Beach
FOR INFORMATION WRITE:	Michael S. Gordon, M.D., Professor of Medicine, Program Director, University of Miami School of Medicine, Section of Cardiology (D39) P.O. Box 016960, Miami, Florida 33101, Telephone: (305) 547-6491.

Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Sniff, Sniff, Al-er-gee by Claude A. Frazier, M.D. and illustrated by Paul H. Carlson. 36 Pages. Price $5.65 (hardcover) $2.65 (paperback). John Reads, Inc., St. Petersburg, 1978.

This book entitled Sniff, Sniff Al-er-gee by Claude A. Frazier, M.D. and illustrated by Paul H. Carlson is written for young children before their first visit to an allergist. Dr. Frazier states in his foreword that "children need to be prepared about what to expect. That is the intent of this book." Certainly any effort extended in this direction of patient pre-education is a step forward in the practice of medicine.

It is written simply and accurately so that children going to an allergist will have some idea of what is ahead for them; however, it is overly long. The black and white illustrations are bland. The book describes a specific illness, allergic rhinitis and deals with only the scratch method of allergy testing and for many allergists this describes methods not done and is not helpful.

In summary, this book is a worthy effort for the patient education of children. However, in the opinion of this reviewer, it is somewhat too specific regarding both illness and what to expect. It suffers from being overly long, is not attractive and not readable for very young children.

Ira Finegold, M.D.
Hollywood

Dr. Finegold practices allergy in Hollywood, Florida.

The New Old: Struggling for Decent Aging edited by Ronald Gross, Beatrice Gross and Sylvia Seidman. 510 Pages. Price $5.95. Anchor Press/Doubleday & Co., New York, N.Y., 1978.

All of us will eventually face problems described in this book, that is, if you aren't already doing so. Being old is the one minority we can all expect to be a part of, so, if this book isn't about your present, it is about your future. Anxiety of growing old runs deep and while this book does not solve the problems of growing old, it certainly presents a helpful listing of resources and information, including publications, organizations and services.

The distressing conditions of old people "waiting for the end" are discussed, along with death, institutionalization, retirement, promising programs around the country; resources and informtion for help; and most important, the joys and rewards of old age.

I can't think of anyone past the age of 30 who should not read and enjoy this book.

L.R.

The Health Practitioner in Family Relationships: Sexual and Marital Issues by Eugenia L. Gullick, Ph.D. and Steven F. Peed, Ph.D. 143 Pages. Price $15.00, Technomic Publishing Co., Inc., Westport, Connecticut, 1978.

Continuing medical education and human sexuality seem to have been made for each other. While both have been around for some time, interest bordering on obsession, really got going a dozen or so years ago. The editors of this small but expensive (10¢ a page) book have successfully reworked a workshop held in Virginia for primary health care providers into an informative, readable and balanced presentation of human sexual function and problems. All that is missing are the explicit films.

In an attempt to include among their readers such diverse groups as ministers, social workers, psychologists and nurses, the authors use the awkward and vague terms "health practitioner" and "primary health care" when they really mean physicians and general medical practice, which leads me to the one real shortcoming of the book. That is, the lack of a chapter by an experienced practicing general physician. The token G.P. included in the list of authors is a talented but nonpracticing researcher and academician. Nevertheless, the book is a reasonable substitute for a weekend workshop about human sexuality, except for the lack of CME credits and the need to supply your own dirty movies.

Lynn P. Carmichael, M.D.
Miami

Dr. Carmichael is Professor and Chairperson, Department of Family Medicine, University of Miami School of Medicine, Miami.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Annual Review of Neuroscience with 28 contributing authors. 506 Pages. Illustrated. Price $17.00. Annual Reviews, Inc., Palo Alto, California, 1978.

Pharmacological and Toxicological Perspectives of Commonly Abused Drugs by Darryl Inaba, Ph.D., E. Leong Way, Ph.D., Kenneth Blum, Ph.D. and Sidney H. Schnoll, M.D. 44 Pages. National Drug Abuse Center, Rosslyn, Virginia, 1978.

Currents in Alcoholism, Biological, Biochemical, and Clinical Studies, Edited by Frank A. Seixas, M.D. 601 Pages. Illustrated. Price $31.50. Grune & Stratton, Inc., New York, 1978.

Controlling the Use of Therapeutic Drugs: An International Comparison edited by William M. Wardell. 263 Pages. American Enterprise Institute for Public Policy Research, 1978.

Visionetics, The Holistic Way to Better Eyesight by Lisette Scholl with John Selby. 222 Pages. Illustrated. Price $4.95. Doubleday & Company, Inc., New York, 1978.

Directory of Pathology, Training Programs 1979-80 by the Intersociety Committee on Pathology Information, Inc. 470 Pages. Illustrated. Price $25.00. Geo. W. King Co., Baltimore, 1978.

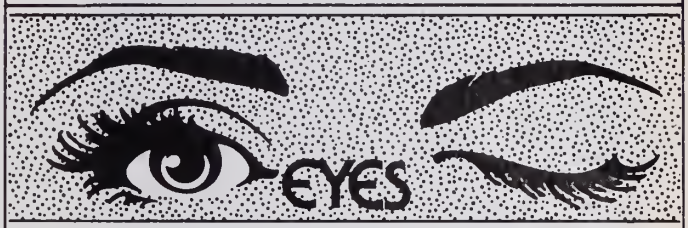
General Urology, 9th Edition, by Donald R. Smith, M.D. 541 Pages. Illustrated. Price $14.50. Lange Medical Publications, Los Altos, California, 1978.

Wholistic Dimensions in Healing, A Resource Guide by Leslie J. Kaslof. 295 Pages. Illustrated. Price $7.95. Doubleday & Company, Inc., Garden City, New York, 1978.

No one can make you feel inferior without your consent.

Eleanor Roosevelt

MEDICAL MESSAGE
from the Florida Doctors



Laser-light shows are the newest burning sensation hitting discotheques and rock concerts. But if you watch too closely, that burning sensation may be in your eyes!

The laser lights used in the shows produce a beam of light so intense that if directed or even reflected into the eyes, it can cause instant and permanent damage by blistering or burning the retina. The FDA is taking care to regulate laser light shows, but only you can take care of your eyes. Being aware of some simple precautions can help you protect and preserve your eyesight. Your Florida doctors offer the following safety suggestions:

- If your work or hobby exposes you to flying particles, such as when sanding wood or glass, wear protective glasses that fit snugly and will keep the particles out.
  Protective glasses should also be worn when playing sports such as tennis or racquetball. The impact of the ball hitting the eye can cause serious damage.
- Wear sunglasses only when exposed to bright sunlight, such as at the beach or when driving. Wearing sunglasses when unnecessary can cause the eyes to become light sensitive and you may experience great discomfort without them.
- If you wear glasses or contacts, be sure they fit well and learn to care for them properly. Don't hesitate to consult your physician if you have difficulty in care, comfort or correction.
- Never rub your eyes. If a foreign particle lodges itself in your eye, the natural action of the tears should wash it out. Rubbing may cause the particle to scratch the eye. If the particle is visible and will not wash out, use a moistened cotton swab to remove it. If the particle is imbedded and cannot be easily removed, consult your ophthalmologist.
- An eye examination should be conducted every two years. An ophthalmologist is a medical doctor who can test your vision. He can also diagnose and surgically treat eye disease. An optometrist can test your vision and prescribe and fit you with glasses or contacts.
- Your eyesight is precious and, once lost, it often can't be replaced. Take the time to care for your eyes and you will "see" a brighter future.

This is a medical message from the Florida Medical Association on behalf of the doctors of Florida and as a public service



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Program Coordinator: Jose S. Bocles, M.D.

THE OBJECT OF THIS COURSE, THE FOURTEENTH IN ITS SERIES, IS TO PROVIDE AN ANNUAL UPDATING OF THE MOST USEFUL RECENT ADVANCES IN THE DIAGNOSIS AND MANAGEMENT OF INTERNAL MEDICAL DISORDERS AS THEY ARE ENCOUNTERED BY PRIMARY CARE PHYSICIANS AND PRACTICING SPECIALISTS.

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Each subspecialty will be introduced by a State of the Art Lecture given by a distinguished authority.

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An extensive program will be offered daily.

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The Learning Center consists of video tapes and fully automatic synchronized cassette/slide projection of lectures. This center will be available during the evenings.

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The hotel, presently under complete renovation, has several golf courses with complimentary green fees provided, two swimming pools, private beach ice skating rink, complete gymnasia, bowling lanes, tennis courts, shuffle-board and a billiard room.

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SUPERVISED CME ACTIVITIES: 35 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that this continuing medical education offering meets the criteria for 35 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed. Approval by the American Academy of Family Physicians for prescribed hours will be applied for.

SELF-INSTRUCTIONAL MATERIALS: 25 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that when these continuing medical education materials are used as directed, they meet the criteria for 25 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association.

REGISTRATION: $350—Physicians $200—*Physicians in training. **For Registration and Information write to:** J. BOCLES, M.D., Department of Medicine, University of Miami School of Medicine, P.O. Box 016760, Miami, Florida 33101, Phone: (305) 547-6063.

*Letter from Chief of Service must accompany registration.



Twenty Florida Physicians . . . have been admitted to Fellowship in the American College of Cardiology. C. Richard Conti, M.D., of Gainesville, ACC Governor for Florida, identified the new Fellows as:

Richard S. Arnold, M.D., Daytona Beach; Stanley H. Bernstein, M.D., and Michael S. Marek, M.D., both of Hollywood; Donald A. Conetta, M.D., and Jawahar L. Mehta, M.B.B.S., both of Gainesville; Paul F. Eckstein, M.D., Tampa; John N. Kloraris, M.D., Dunedin; Jay A. Levine, M.D., Roberto C. Mendizabal, M.D., Abdur Rahim, M.B.B.S., and Peter H. Segall, M.D., all of Miami Beach.

Edward M. Neff, M.D., and George L. Vergara, M.D., both of Coral Gables; Donald G. Rosenberg, M.D., North Miami Beach; Joseph G. Sahab, M.D., Leesburg; Joel S. Shulman, M.D., Fort Lauderdale; Edward B. Simon, M.D., Miami; Ira M. Stone, M.D., Ocala; Henry D. Storch, M.D., Jacksonville; and Franklin T. Tew, M.D., Orlando.


Dr. Anderson

Douglas R. Anderson, M.D., of Miami . . . has received the coveted Honor Award from the American Academy of Ophthalmology for outstanding service and contributions to the profession. The award was presented on October 22 at the Academy's Annual Meeting in Kansas City, Mo.

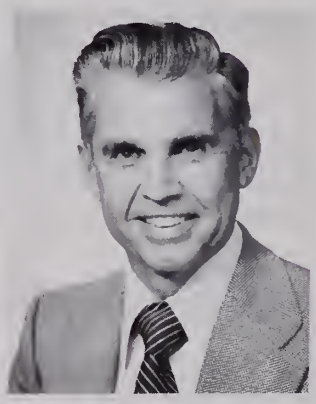
Ophthalmologists become eligible for the award after earning 10 points in the continuing education of fellow ophthalmologists. A physician is awarded one point for each scientific paper, scientific exhibit, instruction course, etc., with a limitation of two points per year.

Dr. Anderson, an Associate Professor of Ophthalmology at the University of Miami School of Medicine, is Associate Editor of the *American Journal of Ophthalmology*. He is a recent recipient of the William and Mary Greve international scholars award for research in blindness prevention.

Gerold L. Schiebler, M.D., of Gainesville . . . has been appointed to the American Medical Association's Ad Hoc Task Force on Juvenile Treatment.

He was among seven physicians named by the AMA Board of Trustees to the Task Force. Dr. Schiebler is Professor and Chairman of the Department of Pediatrics, University of Florida College of Medicine, and is Editor of *The Journal of the Florida Medical Association*.

The AMA Board also named Joseph B. Zagorski, M.D., of Coral Gables as resident member of the Council on Continuing Physician Education.

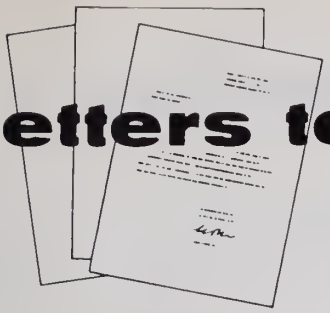

Dr. King

Hueston C. King, M.D., of Coral Gables . . . has been installed as President of the American Society of Ophthalmologic and Otolaryngologic Allergy. He assumed leadership of the organization during its Annual Meeting in Las Vegas in September.

A native of Brooklyn, N.Y., Dr. King attended Princeton University and received his M.D. degree from the College of Physicians and Surgeons of Columbia University in 1954. He has practiced otolaryngology since 1962.

Insurance Commissioner Bill Gunter . . . has levied a $10,000 fine against Blue Cross and Blue Shield of Florida for technical violations of the insurance code. The violations involved the Comprehensive Employers Trust, a 1,500-member group.

Gunter said the Blues admitted they failed to provide adequate coverage for newborns, improperly provided for coordination of benefits against individual contracts and failed to provide for extension of benefits under certain coverages. Gunter said there was no willful intent on the part of the plans.



Letters to the Editors

FROM A LONG-TIME READER

To Dr. Edward Pedrero: Today I read your two articles in the Journal of the FMA and I want to congratulate you on the excellence of your presentations. You certainly have presented problems that we all should strive to answer.

Six weeks ago I had a cataract removed from my left eye with introcular lens implantation. Today I got a trifocal lens for this eye and I now have 20/15 vision. Everything is so clear and distinct and so I have got back to reading my medical journals that I had laid aside for later reading.

James N. Patterson, M.D.
Tampa

(Editor's Note: Dr. Patterson served on the Publications Committee of The Journal in the 1940s and 1950s.)

APPRECIATION

To the Editor: My husband brought home the October issue of the Journal of the Florida Medical Association and I want to thank you for the fine presentation of the Auxiliary Benefit Art Show Awards.

You know in the early 1300's the painters belonged to the Arte dei Medici and Speaiali — the same guild as that of the doctors and pharmacists . . . so we are more closely allied than many would believe at first thought.

You have shown sincere interest and consideration in this matter and for that — please accept my warm feelings of appreciation.

Carol M. Dan
(Mrs. Lewis R. Dan)
Miami Shores

CONGRATULATIONS

To the Editor: My congratulations to you for the fine job you did in putting out the Special Issue on Otolaryngology (September, 1978). Somehow, I failed to receive my copy, but I have received a number of letters from members of the Society who are extremely complimentary and appreciative of this special issue. Your striving for excellence undoubtedly makes *The Journal* one of the finest, if not the finest, state medical journals in the country. This can be accomplished only by dedicated effort on your part.

Again, congratulations on the fine job you are doing with the medical journal.

T. Wallace Hahn, M.D.
Past President
Fla. Society of Otolaryngology
Pompano Beach

(Editor's Note: And congratulations to Dr. Hahn, Guest Editor Troy H. Hutchinson II, M.D., and members of the Florida Society of Otolaryngology, without whose dedicated efforts it would not have been possible.)

MARK THESE DATES

ON YOUR CALENDAR . . .

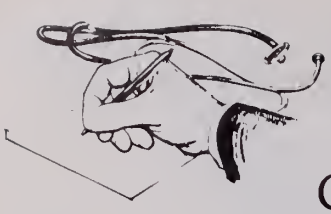
MAY 23-27, 1979

105TH ANNUAL MEETING

FLORIDA MEDICAL ASSOCIATION, INC.

DIPLOMAT HOTEL

HOLLYWOOD-BY-THE-SEA



Others Are Saying

Controlling an Uncontrollable

Edward Pedrero Jr., M.D.

The Office of Management and Budget has listed as "relatively uncontrollable under present law" the billions in spending for Social Security, Medicare, Medicaid, unemployment compensation and civil-service retirement.

In 1965, when Medicare was enacted, the costs for 1975 were projected at $4.3 billion, a conservative actuarial estimate. By official estimates, the **Medicare deficit** in 1990 will be an astronomical $300 billion.

Senate Finance Committees' studies have reported corruption, fraud and abuse in the Medicare program by nursing-home chains, proprietary hospitals, Medicaid-mills, nursing-home operators and physicians.

Physicians are tainted with "guilt by association" by publicity-seeking bureaucrats because the abusers include doctors. Bureaucrats choose to be unaware that medical societies have conscientious, stringent committees on grievances and ethics and have used disciplinary powers on the abusers.

It has been reported that the Medicare payment structure encouraged high fees. It was found that because providers of medical services (hospitals and nursing homes) select the "intermediaries" (the insurance companies), many intermediaries have been reluctant to apply positive administrative requirements with respect to costs. Some intermediaries were found selling insurance to providers they served, creating an implicit conflict of interest.

Studies have found that carriers' performance under Medicare has often been erratic, inefficient and inconsistent with congressional intent. The inefficient carriers were not replaced.

Senate Finance Committee reports have found fault with the Social Security Administration. Instructions were not timely issued, were often too voluminous and detailed and were often not written in clear and concise language.

The plain fact is that it is not the abuses of physicians but many other factors that contribute largely to uncontrollable spending in the Medicare program. The medical profession can not regulate the regulators of Medicare. The waste and inefficiency of the Medicare program should be and can be brought under control.

Medicare's uncontrollable cost can be brought under control by eliminating the frills, fat and waste in the administration of the program.

The tax-expenditure health items for the Department of Health, Education and Welfare (HEW) should be reviewed and passed on annually by the Congress as a part of its appropriations rather than as a tax-writing process. In the examination of HEW's health budget request, the entire program, not just the request for the incremental annual additions, should be reviewed.

HEW Secretary Joseph Califano citing the "sunshine" laws regarding public scrutiny of federal operations has ordered that all Medicare total payments to physicians for the previous calendar year be open to those seeking the information. The records would list the total payments to the physicians under Medicare assignment and payments to patients not on assignment. The cost of compiling the pay data is expected to be over $1 million. This has been postponed because of legal action taken by the Florida Medical Association.

It is time to "Let the Sunshine In" on HEW. A group of cost analysts independent of HEW, should review the tax-expenditure health items and present the results for the public record. Moreover, the views and analysis of HEW's critics should be public documents presented in public proceedings.

The cry that the spending in the Medicare program is uncontrollable is a **shibboleth** devised to aid the bureaucrat in crossing the fords of public irresponsibility.

The uncontrollable spendings in health care can be controlled. This is not the time for us to consider quitting our medical organizations, nor for the organizations to quit on us.

This is the time to join in a cause that should supercede all others — the maintaining of the private practice of medicine.

Reprinted from the READ AND REFLECT section of The Bulletin of the Hillsborough County Medical Association, October 1978.

Issues We Must Face

Edward J. Sullivan, M.D.

Court decisions in different states within the last couple of weeks should be of interest to all physicians. A Massachusetts appeal court has ruled that "do not resuscitate" orders are appropriate for terminally ill patients. This decision clarifies an earlier ruling that apparently led many hospitals, on advice of their legal counsel, to attempt resuscitation of all dying patients in spite of the wishes of the families and desires of their attending physicians. The specific case in point was a patient with Alzheimer's disease who was in a vegetative state. The court wisely decided that the patient presented "a question peculiarly within the competence of the medical profession regarding appropriate measures to ease the imminent passing of an irreversibly, and terminally ill patient in light of the patient's condition and the wishes of her family."

June 16, 1978, a four year old Minnesota girl on a respirator was pronounced dead based on Minnesota Medical Association adopted criteria for a definition of brain death. Fear of legal complications led the hospital to seek district court permission before discontinuation of "life" support. In that state, the MMA ad hoc committee on death is advocating physicians' write "do not resuscitate" on charts of terminally ill or severely brain damaged patients. (Minnesota does not have a brain death law and thus is governed by the common law definition of death — absence of respiration and circulation — the same as in Florida). On June 11, 1978, the state Supreme Court decided in favor of the hospital discontinuing the artificial respiration of the "brain dead" patient.

Closer to home, on July 12, 1978, a Fort Lauderdale judge ruled that a "mentally competent" patient in terminal stages of amyotrophic lateral sclerosis would not be committing suicide if he exercised his constitutional right of privacy and caused discontinuation of artifical respiratory support and, in effect, ruled that termination of such extraordinary treatment by another acting on the patient's wishes is not homicide, but is the result of free exercise of the constitutional right of privacy and in such cases, the death that ensues is expiration of natural causes.

Physicians should be encouraged to write "do not resuscitate" in appropriate cases and should not hesitate to make the medical diagnosis of "death" based on the soundest medical criteria. Once the patient has been determined to be dead, there is no longer any valid reason to continue artificial respiration, kidney dialysis, or artificial heart pacing, vasopressors etc. that so often complicate the terminal event. The family naturally should be kept informed and given the opportunity for consultation if that is their wish.

These are issues that we must face. We must not expect government programs and insurance companies to continue to pay for intensive hospital care of dead bodies. I believe this is an issue that PSRO should appropriately address itself to.

Reprinted from the President's Corner of the St. Luke's Medical Staff News, August, 1978.

Dr. Sullivan is Medical Staff President, St. Luke's Hospital, Jacksonville.

Editor's Note: The following is a ruling the Fourth District Court of Appeals upheld in the Broward County Circuit Court in regard to the amyotrophic lateral sclerosis patient regarding his right of self determination in the matter of artificial respiration.

Death "Right" Upheld

A state appeals court ruled Wednesday that a dying South Florida man is competent to order his doctors to unplug the respirator that keeps him alive.

"Abe Perlmutter should be allowed to make his choice to die with dignity, notwithstanding over a dozen legislative failures in this state to adopt suitable legislation in this field," said the opinion written by Judge Gavin Letts.

Perlmutter, 72, a patient at Florida Medical Center near Fort Lauderdale, suffers from amyotrophic lateral sclerosis, commonly called Lou Gehrig's disease. It is a debilitating nerve disorder that cripples its victims and eventually kills them.

Neither Perlmutter nor his lawyer was immediately available for comment.

The opinion upheld the ruling of Broward Circuit Judge John Ferris, and rebuffed attempts of the state attorney general's office to bar Perlmutter from having his way.

The 4th District Court of Appeal acknowledged issues of medical ethics and the official interest in avoiding any legal disputes that might arise if Perlmutter did have his respirator disconnected, and died because of it.

"However, it is quite another matter to do so at the patient's sole expense and against his competent will, thus inflicting never-ending physical torture on his body until the inevitable, but artifically suspended, moment of death," the three-judge panel said.

"Such a course of conduct invades the patient's constitutional right of privacy, removes his freedom of choice, and invades his right to self-determine."

The court said this case wasn't like many others in which the courts have weighed right-to-die and legal responsibility issues, because in this one the patient was still competent to make his own decisions.

"We see little difference between a cancer-ridden patient who declines surgery, or chemotherapy, necessary for his temporary survival, and the hopeless predicament which tragically afflicts Abe Perlmutter," the court said.

School Transfer Dilemma

A. Dane Sawyer Jr., M.D.

I would like to take the opportunity in this editorial to discuss a problem which has been a source of irritation to pediatricians and other physicians who care for children in their medical practice. The subject is the onus that the county school system has placed on physicians and psychologists for granting school transfers.

For the past ten years at about the time the fall school term starts, I have had numerous requests for school transfers for various reasons, many not related to medical problems. The parents seek the assistance of a physician, because they are told by a school principal or assignee that the *only* way to get a transfer for *any* reason is with a doctor's written recommendation.

When this concept originally surfaced, I consulted a local school principal who told me that this was a regulation imposed to prevent excessive movement of school children out of integrated schools. I was also informed that the only valid reasons were physical and emotional problems that a child may have related to his assigned school. The term "emotional well being" represents a broad spectrum which can be stretched to include any situation and which is subject to broad interpretation.

When I first began to receive these requests they were predominantly alleged emotional problems arising from racial situations, real or imagined, by the student or his parents. To grant legitimate transfers in these cases has been time consuming, frustrating, and a nonproductive aspect of my pediatric practice.

The doctrine of passing the buck to physicians has evolved into a method absolving school administrators of almost any responsibility regarding transfers. (They will transfer children with special educational needs to schools that have matched programs to fill specific needs, but this is commonly an inexorable process.)

As the process of integration has progressed over the years, the number of parents requesting transfers, based on unhappiness with the ethnic make-up of the classroom, has been replaced by parents concerned about the inequity in the quality of education which exists from school to school and even from teacher to teacher. When confronted with this situation, the physician is faced with the fact that the cause for the parent seeking a transfer is an educational one and the degree of emotional disturbance a child has is an effect of the system. Under these circumstances it is very difficult to make a decision that is justifiable as a physician's responsibility. On occasion I have suggested that the parent submit the facts to a school board member, but I wonder how many have.

We are faced with a dilemma. On one hand I would like to get out of the school transfer business, except for purely medical reasons. If that happens it is a no-win situation, the big losers being the children who need an advocate in this arbitrary bureaucratic quandary.

Reprinted from The Imperial Polk County Medical Association Bulletin, October 1978.

Reaching Out . . . Touching Life

Carl Mays

My son was born and reared in the mountains. He's been close to nature, living a spontaneous life that has been shaped by the freedom of his surroundings. He celebrated his sixth birthday recently — a birthday that introduced him to a new lifestyle.

My son started to school this morning. It's going to be strange and new to him for awhile. And, I wish you would sort of treat him gently.

You see, up to now, you might say that he's been the "king of the mountain." Running barefoot through the grass and bringing bouquets of wild flowers to his mother, he's been surrounded by people who love him deeply. The squirrels and birds and our pet dog have been his playmates.

But now, things are going to be different.

This morning, I drove him into the city. As I let him out in front of the school building, he waved back to me as he approached the steps and started on his great adventure.

To live his life in the world he has to live in will require faith and love and courage. So I wish you would sort of take him by his young hand and teach him the things he will have to know. Teach him. But gently, if you can.

He will have to learn, I know, that not all men are true . . . that unlike the mountains and birds and squirrels and our pet dog, people will sometimes disappoint him and hurt him.

Help him to learn, however, that for every scoundrel, there is a hero — that for every crooked politician, there is a dedicated leader — that for every enemy, there is a friend.

Let him learn early that the bullies are the easiest people to lick.

Teach him the wonders of books. Help him to understand that good books complement the eternal mystery of birds in the sky, bees in the sun, and flowers on the mountain.

Teach him that it is far more honorable to fail than to cheat. Encourage him to have faith in his own ideas, even though everyone else tells him he is wrong.

Try to give my son the strength not to follow the crowd when everyone else is getting on the bandwagon. Teach him to listen to everyone, but to filter all he hears with a screen of truth and to accept only the good that comes through.

Teach him to close his ears to a howling mob — and to stand and fight, if he is right. Teach him that the word AMERICAN ends with "I CAN"!

Teach him gently, but don't coddle him, because only the test of fire makes fine steel.

This is a big order, I know. But see what you can do. He's such a nice little fellow. And today, he left the solitude of the mountains to enter a new world.

Reprinted from Our Smokies Heritage, Gatlinburg, Tennessee, October 1978.

There are two ways of spreading light;
To be the candle or the mirror that reflects it.

Edith Wharton

The Records Mess

R. H. Behnke, M.D.

The rapidly exploding science and technology of communications has already made a tremendous impact upon our daily lives. The network of communication satellites keep whole segments of the world within aural and even visual contact, virtually upon demand. We have printers whose speed is now accounted for in lines per second, rather than the old increment of lines per minute. Letters and pictures are transmitted via telephone lines. While the cost of some of these practices is still excessive, there is little doubt that in the future almost any segment of society can communicate with any other if the need arises with many different techniques.

Unfortunately, absolutely none of the above statements are applicable to the vital communications involved in medical records. Anyone who examines how physicians' office and hospital records are exchanged would simply have to come to the conclusion that it is an utter "mess." Management of these vital patient records has proceeded little beyond the stage of the pony express.

The all too common experience of a patient transferred from one hospital to another expeditiously in an ambulance only to have the medical records, which should have accompanied him, get bogged down at some point in the system from the hospital ward to the mail room to the United States Postal Service. It is difficult to describe the utter frustration the physician now given the responsibility for continuing care experiences in such a situation. The transfer which is obviously to facilitate the recovery or improve the chances of survival of this patient may well be a disaster for the lack of any information which would implement these intents. There is not a physician who has practiced for any length of time who has not resorted to what seems to be the easiest route: send the patient's family back to fetch them.

What then about the records themselves? Having fought the good fight to get them, one then, with certain eagerness, looks forward to what they reveal. In the majority of instances they consist of replicated copies of laboratory and x-ray slips, nursing notes, and fiscal information. If one is lucky, there may be Progress Notes which reveal but dimly what has happened in the antecedent period of time. A complete history and physical examination has virtually become a document to be enshrined in medical archives having been replaced virtually totally by the elegant but brief "admission note." Certainly the professed efficiency of the duplicating processes which "copies as good or better than the original" have never been to any degree realized in the machines in our hospitals and offices. One gets the sense that you might find what you need in the record, but you simply cannot make it out.

Compounding these problems is the fact that no one hospital record in this country really looks like any other. Heaven forbid that this profession, characterized by its individualism, be forced to use any semblance of a standardized form! The Problem Oriented Record which offered some sembalance of reasoned order has died a neonatal death in many hospitals in which it was adopted, but in many others it was not conceived at all.

Even less available are the vast array of elegant x-ray films, scans, and diverse graphics performed upon patients. While most physicians will concede that the chart is indeed the patient's, radiologists and others regard these graphics as their personal property, extracted from their departments only with physical force. One then must rely upon the "reports" written with minimum content, in many instances, in a style with grammar, punctuation, and spelling which would embarrass an elementary student.

The consequences of such practices are far-reaching. Clearly our inefficiency in communication results in both morbidity and mortality which is needless. The cost consequences of such practices are incalculable, for the net result that it is easier to repeat much of what has been done before, simply because it is presently needed for decisions in patient care. It is not at all uncommon for the patient in a single illness to have two of a vast array of costly procedures which in themselves carry considerable inherent risk.

How then can this situation, albeit somewhat overdescribed, be correct? Surely communication scientists, given appropriate authority, could establish records and techniques which would facilitate hospital data transfer as easily as we get our newsprint. The techniques for transfer of all forms of medical records are available. However, there is obviously little hope, for a variety of reasons, that such will come about with any haste over the next few years.

The great single force then in the remediation of this problem is indeed the physician himself. All physicians must clearly believe and support the tenet that good

records are necessary for good medicine. Physicians must accept the responsibility for the transfer of the records as well as for the transfer of the patient. If this attitude is expressed with the force and authority which the physician has, others may find this concern contagious.

A profession thoroughly convinced that communication is vital to patient care will bring the advanced technologies now available to everyday use. Without this fundamental change in the behavior of the many physicians, the patients and their families will still be confused and angered by the ineptness of a so-called learned profession.

Reprinted from The Editor's Column of The Bulletin of the Hillsborough County Medical Association, November 1978.

ONE-SEVENTH OF YOUR EMPLOYEES MAY BE DYING. HELP SAVE THEIR LIVES.

High Blood Pressure is the country's leading contributor to stroke, heart disease and kidney failure. Any of which can kill.

And, one out of every seven of your workers has it. Half have no idea they're walking around with this time bomb inside them: there are usually no symptoms.

But you can help. By sending for a special kit, "Guidelines for High Blood Pressure Control Programs in Business and Industry." Write to: National High Blood Pressure Education Program, 120/80, National Institutes of Health, Room 1012—Landow Bldg., Bethesda, Md. 20014.

HIGH BLOOD PRESSURE. Treat it...and live.

The National High Blood Pressure Education Program, U.S. Department of Health, Education, and Welfare.

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MEETINGS

Approved by the FMA Committee on Continuing Medical Education

JANUARY

The 6th Annual Symposium in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Jan. 3-6, Miami.*

2nd Annual Oral Pathology Review, Jan. 8-12, Jackson Memorial Hospital, Miami.*

Art and Science in Therapy of Difficult Problems in Surgery, Jan. 10-13, Americana Hotel, Miami Beach.*

Postgraduate Seminar in Pediatric and Adult Urology, Jan. 10-13, Carillon Hotel, Miami Beach. For information: Victor Politano, M.D., 6614 Miami Lakes Drive, East Miami Lakes 33014 or phone (305) 822-6000.

The Biology & Psychopharmacology of Depression, Jan. 13-14, Innisbrook Golf & Country Club, Tarpon Springs. For information: Howard L. Masco, M.D., 1801 South Boulevard, New Port Richey 33552.

Continuing Education in Pediatrics, Jan. 14-18, Diplomat Resorts, Hollywood Beach. For information: Donald H. Altman, M.D., 6125 Southwest 31st Street, Miami 33155.

First Annual Walt Disney World Pulmonary Wintercourse, Jan. 15-18, Contemporary Hotel, Lake Buena Vista. For information: Asher Marks, M.D., P.O. Box 8127, Jacksonville 32211.

Annual Seminar in Otolaryngology, Jan. 15-18, Doral Country Club and Hotel, Miami Beach.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Jan. 15-20, Jackson Memorial Hospital, Miami.*

Miami Winter Symposia, Jan. 22-28, Intercontinental Hotel, Miami.*

4th Annual Review and Recent Practical Advances in Pathology, Jan. 23-26, Konover Hotel, Miami Beach.*

Psycho-Social Aspects of Cleft Palate, Jan. 26-27, Lake Buena Vista. For information: Frances S. Smith, M.D., 1736 University Blvd., S., Jacksonville 32216.

Winter Conference on Principles of Practice Management, Jan. 27-Feb. 3, Lion Square Lodge, Vail, Colorado.*

Vail Conference in Intensive Care, Jan. 27-Feb. 3, The Mark Resort, Vail, Colorado.*

***For information: Contact Division of Continuing Medical Education, D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

1979 Ear Surgery Course, Jan. 28-Feb. 1, Holiday Inn Central, Tampa. For information: J. Brown Farrior, M.D., 509 Bay Street, Tampa 33606.

International GI-Family Practice Clinical Conference, Jan. 28-Feb. 2, Dutch Inn, Lake Buena Vista. For information: Orris O. Rollie, M.D., 601 E. Rollins, Orlando 32803.

Laparoscopy Course, Jan. 29-30, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

A Neurological Update 1979, Jan. 29-Feb. 3, Konover Hotel, Miami Beach.*

FEBRUARY

24th Central Florida Medical Meeting, Feb. 1-4, Contemporary Resort Hotel, Lake Buena Vista, Florida. For information: Sam F. Elder, M.D., 601 Rollins Avenue, Orlando 32803.

Morton F. Plant Heart Center, 3rd Annual Cardiovascular Symposium-Valvular Heart Disease in Adults, Feb. 2-3, Caribbean Gulf Hotel, Clearwater Beach. For information: Donald R. Eubanks, M.D., 323 Jeffords St., Clearwater 33517.

Second Symposium on Neurological Surgery of the Ear, Feb. 3-8, Sarasota. For information: Ms. Susan G. Brown, 1845 Hillview Street, Sarasota 33579.

Fifth Annual Vail Conference in Anesthesiology, Feb. 3-10, The Mark Resort, Vail, Colorado.*

Obstetrical and Gynecological Ultrasound In-Service Workshop, Feb. 5-9, Jackson Memorial Hospital, Miami.*

Florida Midwinter Seminar in Ophthalmology and Otolaryngology, Feb. 5-10, Americana Hotel, Miami Beach.*

Gastroenterology Today: For the Clinician, Feb. 9-11, Dutch Inn, Lake Buena Vista.**

Fourteenth Annual Postgraduate Course "Internal Medicine 1979", Feb. 11-16, Fontainebleau Hilton Hotel, Miami Beach.*

Imageology 1979, Feb. 16-23, Konover Hotel, Miami Beach. For information: Mrs. Lucy E. Kelley, c/o Medical Seminars, P.O. Box 343762, Coral Gables 33134.

Pediatric Dermatology Seminar, Feb. 17-26, M/S Buccaneer, Galapagos Islands, South America. For information: Guinter Kahn, M.D., 16800 Northwest 2nd Ave., Suite 401, North Miami Beach 33169.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Feb. 19-24, Jackson Memorial Hospital, Miami.*

Management of the Tiny Baby — 1979, Feb. 22-23, Dutch Inn, Lake Buena Vista. For information: Keith S. Kanarek, M.D., 1416 South Orange Avenue, Orlando, Florida 32806.

OB-GYN Cruise Seminar, Feb. 24-Mar. 6. (Cruise line to be announced).*

12th Pan American Congress of Ophthalmology, Feb. 25-Mar. 2, Fontainebleau Hotel, Miami Beach.*

Laparoscopy Course, Feb. 26-27, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Basic Neurology for Psychiatrists, Family Practitioners and General Practitioners, Feb. 26-Mar. 2, Konover Hotel, Miami Beach.*

Teaching Conference in Clinical Cardiology, Feb. 28-Mar. 3, Americana Hotel, Miami Beach.*

Eleventh Teaching Conference in Clinical Cardiology, Feb. 28Mar. 3, Americana Hotel, Bal Harbour.*

MARCH

Gynecologic Endocrinology and Infertility, Mar. 1-3, Orlando Hyatt House, Orlando. For information: Bernard Cantor, M.D., Dept. Ob. Gyn., Box J-294, JHMHC, Univ. of Fla., Gainesville 32610.

6th Annual Topics in Urology, Mar. 1-3, Gainesville Hilton, Gainesville.**

Skin 1979: Modern Management of Common Skin Diseases, Mar. 2-4, Carillon Hotel, Miami Beach.*

Symposium on Management of Uveal Melanomas, Mar. 3, University of South Florida College of Medicine, Tampa.+

Postgraduate Medical Refresher Course, Mar. 5-15, Galt Ocean Mile Hotel, Fort Lauderdale. For information: Donald R. Lannin, M.D., 832 Central Medical Building, St. Paul, Minnesota 55104.

Medical Imaging 1979, Mar. 8-10, Royal Biscayne Hotel, Miami.*

Medical Hypnosis and Short-Term Psychotherapy, Mar. 10-14, Americana Hotel, Miami Beach.*

Current Trends in Radioimmunoassay 1979, Mar. 11-13, Royal Biscayne Hotel, Miami.*

Problems in Rheumatology, Mar. 15-18, Don CeSar Beach Resort Hotel, St. Petersburg Beach.+

10th Annual Topics in Internal Medicine, Mar. 22-24, Hyatt House, Kissimmee.**

American and European Views on Anesthesiology, Mar. 24-31, Zermatt, Switzerland.*

Laparoscopy Course, Mar. 26-27, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

Medical Imaging Seminar II, Mar. 28-31, Konover Hotel, Miami Beach. For information: June K. Allen, 4300 Alton Road, Miami Beach 33140.

APRIL

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 9-14, Jackson Memorial Hospital, Miami.*

Laparoscopy Course, Apr. 23-24, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

The Impact of Basic Research Today on Clinical Medicine Tomorrow, Apr. 26-29, Sarasota. For information: Charles R. Estill, 1865 Hawthorne Street, Sarasota 33579.

Sarasota Medical Awards Conference, Apr. 26-29, Hyatt House, Sarasota. For information: S. P. Bralow, M.D., 1515 South Osprey Ave., Sarasota 33579.

Seventh Annual Surgical Intensive Care Symposium, Apr. 27-30 (location to be announced).*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 30-May 5, Jackson Memorial Hospital, Miami.*

MAY

7th Annual Intensive Care Symposium, May 4-7, Eden Roc Hotel, Miami Beach.*

Ultrasound (General) In-Service Workshop, May 7-11, Jackson Memorial Hospital, Miami.**

9th Family Practice Review, May 16-19, Gainesville Hilton, Gainesville.**

Laparoscopy Course, May 28-29, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

JUNE

Master Approach to Cardiovascular Problems — 7th Annual Conference, June 8-10, The Contemporary Hotel, Lake Buena Vista.*

Laparoscopy Course, June 25-26, University Hospital, Jacksonville. For information: Robert J. Thompson, M.D., 655 West 8th Street, Jacksonville 32209.

If money is your only hope for independence, you will never have it. The only real security that a man can have in this world is a reserve of knowledge, experience and ability.

Henry Ford

Florida Organizations of Medical Interest Meetings and Officers

Organization	President	Secretary	Annual Meeting
Florida Medical Association	O. William Davenport, Miami	Robert E. Windom, Sarasota	Hollywood-by-the-Sea May 23-27, 1979
Florida Specialty Societies			
Allergy Society	Sam C. Bukantz, Tampa	Ira Finegold, Hollywood	
Anesthesiologists, Society of	John C. Kruse, Jacksonville	John L. Weare, Melbourne	
Chest Phys., Fla. Chap., Am. Col.	Roberto Llamas, Miami Beach	Marcos Barrocas, Miami	
Colon & Rectal Surgeons, Soc. of	Walter W. Hamilton, St. Petersburg	Shedric H. Roberson, Dayt'a Bch.	
Dermatology, Society of	Daniel Roberts, Rockledge	Dale R. Charneco, Jacksonville	
Emergency Phys., Fla. Chap.	Frederick C. Wurtzel, Orlando	No Secretary	
Endocrine Society	Yank D. Coble Jr., Jacksonville	Henry J. Baskin, Orlando	
Family Physicians, Acad. of	Bernard Kimmel, W. Palm Beach	Guy T. Selander, Jacksonville	
Gastroenterologic Society	Walter E. Morris, Jacksonville	Pedro J. Greer, Miami	
Internal Medicine, Society of	Rose P. London, Miami Beach	Charles P. Hayes, Jacksonville	
Neonatal-Perinatologists, Soc. of	John S. Curran, Tampa	Robert Nelson, Gainesville	
Nephrology, Society of	Robert A. Metzger, Orlando	James L. Katsikas, Miami	
Neurology, Society of	William M. Maycook, Jacksonville	Beauregard L. Bercaw, Largo	
Neurosurgical Society	Albert L. Rhoton, Gainesville	Frank M. Davis, Tallahassee	
Nuclear Physicians, Assn. of	Fuad S. Ashkar, Miami	Carl H. Weidenmier, Jacksonville	
Obstetric and Gynecologic Society	George N. Lewis, Tallahassee	Taylor H. Kirby Jr., Gainesville	
Oncology, Clin., Fla. Soc.	Jack W. MacDonald, Tallahassee	Ellen Sayet, Fort Myers	
Ophthalmology, Society of	Gene L. Davidson, Tallahassee	Thomas S. Edwards, Jacksonville	
Orthopedic Society	James F. Richards, Orlando	Creighton L. Wilson, Miami	
Otolaryngology, Society of	James C. Garlington, Gainesville	John A. Coleman, Winter Park	
Pathologists, Society of	Matthew C. Patterson, Jacksonville	Morton J. Robinson, Miami Beach	
Pediatric Cardiologists, Assn. of	Robert H. Miller, Jacksonville	Delores F. Tamer, Miami	
Pediatric Surgeons, Assn. of	James L. Talbert, Gainesville	Ralph L. Swank II, Tampa	
Pediatric Society, Fla. Chap. Am. Acad. of Pediatrics	Michael L. Steiner, W. Palm Beach	Myrna B. Ginter, Jacksonville	
Physical Medicine and Rehab., Soc. of	Charles J. Kurth, Orlando	Solomon Winokur, Lake Worth	
Physicians, Am. Col.	Charles K. Donegan, St. Petersburg	No Secretary	
Plastic & Recon. Surgery, Soc. of	John R. Royer, Winter Park	C. Gary Zahler, Miami	
Preventive Medicine, Soc., of	James T. Howell, Palm Springs	John F. McGarry, Orlando	
Psychiatric Association	Bernard Tumarkin, Coral Gables	Philip B. Phillips, Pensacola	
Radiological Society	John T. Johnson, Sanford	Donald R. Hansard, Tallahassee	
Rheumatology, Society of	Richard S. Panush, Gainesville	Wilbur J. Blechman, North Miami Beach	
Surgeons, Fla. Chap., Am. Col.	Arthur L. Trask, Boynton Beach	Arthur K. Waltzer, Tampa	
Surgeons, General Assn. of	Phil D. Morgan, Vero Beach	Robert H. Hux, Leesburg	
Surgeons, Surg. Div., Intnl. Col.	Julian A. Rickles, Miami Beach	Michael B. Butler, Orlando	
Surgeons, Thor. & Card., Soc. of	Richard G. Connar, Tampa	Parry B. Larsen, Miami	
Thoracic Society	Alan Jay Block, Gainesville	Dean D. Mergenthaler, N. Palm Beach	
Urological Society	Alvie C. McCully, Tallahassee	H. A. P. Leininger, Coral Gables	
FLORIDA DIVISION:			
American Cancer Soc., Inc.	Robert H. Wichman, Tampa	Barbara Weintraub, Tampa	Orlando, April 21, 1979
American Heart Assn., Fla. Aff.	Donald J. Fraser, Orlando	Mrs. W. H. Elarbee, Vero Beach	Lake Buena Vista, May 25-27, 1979
Arthritis Foundation, Fla. Chap.	Earl Treadway, Tallahassee	Christia Scarborough, Sarasota	Orlando, May 1979
Blue Shield of Florida, Inc.	J. W. Herbert, Jacksonville	John S. Slye, Jacksonville	Hollywood, May 23-27, 1979
Board of Medical Examiners	Leo Grossman, Miami Beach	Robert C. Palmer, Pensacola	Tampa, Jan. 19-23, 1979
Crippled Children & Adults, Easter Seal Society, Inc.	George F. Platts, Ormond Beach	Mrs. Richard Eiland, Miami	Orlando, Jan. 27, 1979
Epilepsy Foundation, Inc.	Mark Buchbinder, Miami	Dot Cozzens, Largo	Sarasota, December 1, 1978
Kidney Foundation, National	(Not available)		
Leukemia Society of America	Irving J. Whitman, Miami	Robert H. Newman, Miami	Orlando, March 3, 1979
Lung Association	William E. Culbreath, St. Petersb'g	Earl L. Crona, Pensacola	Jacksonville, April 5-7, 1979
March of Dimes, National Foundation	Lou Creekmur, Miami	Mrs. M. E. Thompson Jr., Miami	Miami, Spring of 1979
Mental Health Association	Richard M. Gray, Jacksonville	Roma Reyner, Palm Springs	(To be determined)
National Multiple Sclerosis Soc.	O. G. Howell Jr., Palm Beach	Mrs. Connie Chauncey, W. P. Bch.	(Not available)
Prevention of Blindness, Inc.	Will H. Wasson, Jacksonville	Arthur G. Garrison, Tampa	Tampa, February 3-4, 1979
Retarded Citizens, Assn. for	Trevor G. Smith, Tampa	George Williams, Quincy	Tallahassee, January 20, 1979
United Cerebral Palsy, Inc.	J. O. Kemp, Jacksonville	Don L. Asher, Orlando	Tampa, December 9, 1978

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FAMILY PRACTITIONER. Growing community in northeast Florida offers immediate opportunity to establish private practice. Excellent schools, beautiful beaches, year-round outdoor recreation. Contact: Claude Weeks, Executive Director, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

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FAMILY PRACTITIONER: Two-man family practice looking for third man. Location South Florida, Pompano Beach area. Write: P.O. Box 757, Pompano Beach, Florida 33060.

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INTERNIST-NEUROLOGIST, 33, university trained, in two specialties. Would prefer to practice both Internal Medicine and Neurology in multispecialty group or other community situation. Write to Box 221, Glen Oaks, New York 11004.

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UNIVERSITY TRAINED GENERAL SURGEON wishes to join practice. Contact: M. Lane, M.D., 7901 Henry Avenue, Philadelphia, Pennsylvania 19128.

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ORTHOPEDIC SURGEON, 31, board eligible, currently fellow in hand surgery, Florida licensed; Seeks practice opportunity — group or partnership, preferably Southeast Florida or Tampa. Available January 1979. Reply Geoffrey Coll, M.D., 8960 N.W. 8th St., #402, Miami, Florida 33172.

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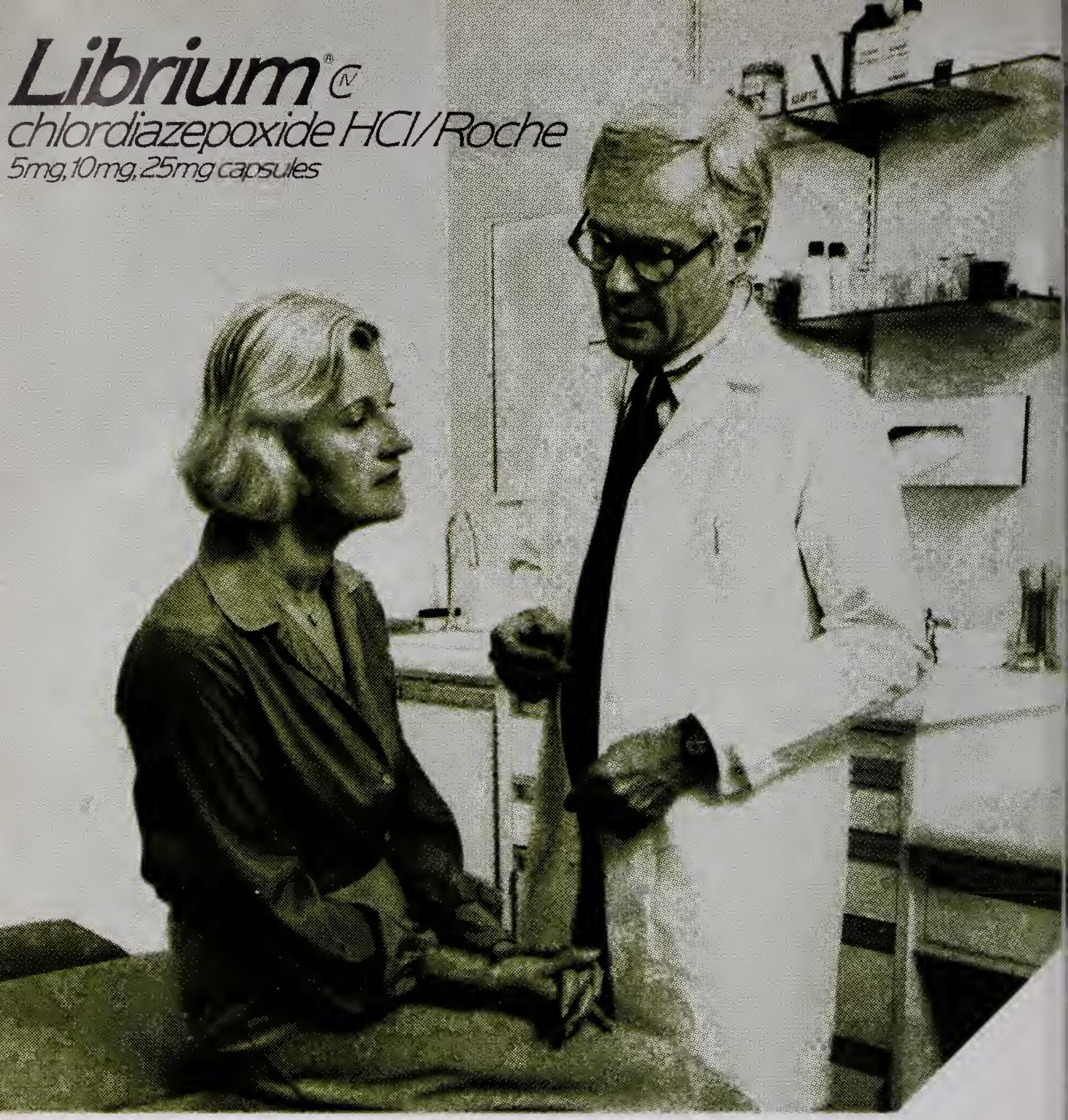
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